

## Calendar No. 336

113TH CONGRESS  
2D SESSION**S. 2157**

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 25, 2014

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

MARCH 26, 2014

Read the second time and placed on the calendar

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**A BILL**

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

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

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

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

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE PAYMENT FOR PHYSICIANS' SERVICES

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

Sec. 102. Priorities and funding for measure development.

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

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

Sec. 105. Promoting evidence-based care.

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

Sec. 107. Expanding availability of Medicare data.

Sec. 108. Reducing administrative burden and other provisions.

TITLE II—EXTENSIONS

Subtitle A—Medicare Extensions

Sec. 201. Work geographic adjustment.

Sec. 202. Medicare payment for therapy services.

Sec. 203. Medicare ambulance services.

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

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

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

Sec. 207. Reasonable cost reimbursement contracts.

Sec. 208. Quality measure endorsement and selection.

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

Subtitle B—Medicaid and Other Extensions

Sec. 211. Qualifying individual program.

Sec. 212. Transitional Medical Assistance.

Sec. 213. Express lane eligibility.

Sec. 214. Pediatric quality measures.

Sec. 215. Special diabetes programs.

Subtitle C—Human Services Extensions

Sec. 221. Abstinence education grants.

Sec. 222. Personal responsibility education program.

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

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

TITLE III—MEDICARE AND MEDICAID PROGRAM INTEGRITY

Sec. 301. Reducing improper Medicare payments.

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

#### TITLE IV—OTHER PROVISIONS

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

#### TITLE V—AMENDMENT TO OCO ADJUSTMENTS

- Sec. 501. Amendment to OCO adjustments.
- Sec. 502. Limitation on the use of OCO funding.

# 1    **TITLE I—MEDICARE PAYMENT**

# 2    **FOR PHYSICIANS' SERVICES**

## 3    **SEC. 101. REPEALING THE SUSTAINABLE GROWTH RATE**

## 4                    **(SGR) AND IMPROVING MEDICARE PAYMENT**

## 5                    **FOR PHYSICIANS' SERVICES.**

### 6            (a) STABILIZING FEE UPDATES.—

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

(A) in subsection (d)—

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

(ii) in paragraph (4)—

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

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

(B) in subsection (f)—

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

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

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

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

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

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

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

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

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

21 (3) MEDPAC REPORTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10                  (ii) in clause (ii)—

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

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

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

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



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

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

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

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

23 (2) QUALITY REPORTING.—

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

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

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

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

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

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

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

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

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

24 (ii) in subsection (m)—

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

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

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

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

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

16 (3) VALUE-BASED PAYMENTS.—

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

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

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

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

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

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

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

(c) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

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

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

5           “(1) ESTABLISHMENT.—

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

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

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

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

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

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

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

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

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

1 group that includes such profes-  
 2 sionals; and

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATIONS.—

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

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

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

“(D) APPLICATION TO GROUP PRACTICES.—

“(i) IN GENERAL.—Under the MIPS:

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

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

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

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

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

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

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

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

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

1 “(G) ACCOUNTING FOR RISK FACTORS.—

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

16 “(ii) ACCOUNTING FOR OTHER FAC-  
17 TORS IN PAYMENT ADJUSTMENTS.—Tak-  
18 ing into account the studies conducted and  
19 recommendations made in reports under  
20 section 101(f)(1) of the Commonsense  
21 Medicare SGR Repeal and Beneficiary Ac-  
22 cess Improvement Act of 2014 and other  
23 information as appropriate, the Secretary  
24 shall account for identified factors with an  
25 effect on quality and resource use outcome

1 measures when determining payment ad-  
 2 justments, composite performance scores,  
 3 scores for performance categories, or  
 4 scores for measures or activities under the  
 5 MIPS.

6 “(2) MEASURES AND ACTIVITIES UNDER PER-  
 7 FORMANCE CATEGORIES.—

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

14 “(i) Quality.

15 “(ii) Resource use.

16 “(iii) Clinical practice improvement  
 17 activities.

18 “(iv) Meaningful use of certified EHR  
 19 technology.

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



1 “(i) QUALITY.—For the performance  
2 category described in subparagraph (A)(i),  
3 the quality measures included in the final  
4 measures list published under subpara-  
5 graph (D)(i) for such year and the list of  
6 quality measures described in subpara-  
7 graph (D)(vi) used by qualified clinical  
8 data registries under subsection (m)(3)(E).

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

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

1                   “(I) The subcategory of expanded  
2                   practice access, which shall include ac-  
3                   tivities such as same day appoint-  
4                   ments for urgent needs and after  
5                   hours access to clinician advice.

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

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

20                  “(IV) The subcategory of bene-  
21                  ficiary engagement, which shall in-  
22                  clude activities such as the establish-  
23                  ment of care plans for individuals  
24                  with complex care needs, beneficiary  
25                  self-management assessment and

1 training, and using shared decision-  
2 making mechanisms.

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

8 “(VI) The subcategory of partici-  
9 pation in an alternative payment  
10 model (as defined in section  
11 1833(z)(3)(C)).

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

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

1 “(C) ADDITIONAL PROVISIONS.—

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

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

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

1 “(iv) APPLICATION OF MEASURES AND  
2 ACTIVITIES TO NON-PATIENT-FACING PRO-  
3 FESSIOALS.—In carrying out this para-  
4 graph, with respect to measures and activi-  
5 ties specified in subparagraph (B) for per-  
6 formance categories described in subpara-  
7 graph (A), the Secretary—

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

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

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

4 “(v) CLINICAL PRACTICE IMPROVE-  
5 MENT ACTIVITIES.—

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

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

21 “(aa) identifying activities  
22 described in subparagraph  
23 (B)(iii);

24 “(bb) specifying criteria for  
25 such activities; and

1 “(cc) determining whether a  
2 MIPS eligible professional meets  
3 such criteria.

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

16 “(D) ANNUAL LIST OF QUALITY MEASURES  
17 AVAILABLE FOR MIPS ASSESSMENT.—

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

1 assessment under this subsection for such  
2 performance period. Pursuant to the pre-  
3 vious sentence, the Secretary shall—

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

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

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

23 “(bb) adding to such list, as  
24 appropriate, new quality meas-  
25 ures; and



1                   “(cc) determining whether  
 2                   or not quality measures on such  
 3                   list that have undergone sub-  
 4                   stantive changes should be in-  
 5                   cluded in the updated list.

6                   “(ii) CALL FOR QUALITY MEAS-  
 7                   URES.—

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

23                  “(II) ELIGIBLE PROFESSIONAL  
 24                  ORGANIZATION DEFINED.—In this  
 25                  subparagraph, the term ‘eligible pro-

1                   fessional organization’ means a pro-  
 2                   fessional organization as defined by  
 3                   nationally recognized multispecialty  
 4                   boards of certification or equivalent  
 5                   certification boards.

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

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

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

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

such measure, including clinical and other data supporting such measure.

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

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

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

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

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

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

1 such qualified clinical data registries on  
2 the Internet website of the Centers for  
3 Medicare & Medicaid Services.

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

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

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

23 “(viii) CONSULTATION WITH REL-  
24 EVANT ELIGIBLE PROFESSIONAL ORGANI-  
25 ZATIONS AND OTHER RELEVANT STAKE-

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

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

“(3) PERFORMANCE STANDARDS.—

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

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

“(i) Historical performance standards.

“(ii) Improvement.

“(iii) The opportunity for continued improvement.

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

10           “(5) COMPOSITE PERFORMANCE SCORE.—

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

10           “(I) QUALITY.—

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

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

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

10          “(II) RESOURCE USE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

“(6) MIPS PAYMENTS.—

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

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

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

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

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

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

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

22 “(iv) in a manner such that—

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

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

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

20 “(B) APPLICABLE PERCENT DEFINED.—

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

23 “(i) for 2018, 4 percent;

24 “(ii) for 2019, 5 percent;

25 “(iii) for 2020, 7 percent; and

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

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

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

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

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

“(D) ESTABLISHMENT OF PERFORMANCE THRESHOLDS.—

“(i) PERFORMANCE THRESHOLD.—

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

“(ii) ADDITIONAL PERFORMANCE THRESHOLD FOR EXCEPTIONAL PERFORM-

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

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

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



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

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

“(II) take into account—

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

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

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

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

“(i) 1, plus

“(ii) the sum of—

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

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

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

“(i) APPLICATION OF SCALING FACTOR.—

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

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

6 “(II) SCALING FACTOR LIMIT.—

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

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

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

17 “(II) AGGREGATE INCREASES.—

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

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

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

16 “(iii) EXCEPTIONS.—

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

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

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

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

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

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

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

17 “(9) PUBLIC REPORTING.—

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

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

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

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

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

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

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

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

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



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

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

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

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

25           “(B) FUNDING FOR IMPLEMENTATION.—

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

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

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

22          “(A) PERFORMANCE FEEDBACK.—

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

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

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

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

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

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

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

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

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

3           “(B) ADDITIONAL INFORMATION.—

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

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

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

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

1 “(13) REVIEW.—

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

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

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

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

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

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

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

19 (2) GAO REPORTS.—

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) IMPROVING QUALITY REPORTING FOR COMPOSITE SCORES.—

(1) CHANGES FOR GROUP REPORTING OPTION.—

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

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

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

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

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

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

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

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

18      (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

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

23      “(c) PHYSICIAN FOCUSED PAYMENT MODELS.—

24          “(1) TECHNICAL ADVISORY COMMITTEE.—

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

6           “(B) MEMBERSHIP.—

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

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

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

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



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

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

13 “(C) TERM; VACANCIES.—

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

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

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

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

“(E) COMPENSATION OF MEMBERS.—

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

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

“(F) OPERATIONAL AND TECHNICAL SUPPORT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5               “(1) PAYMENT INCENTIVE.—

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

1 of Defense or the Secretary of  
2 Veterans Affairs under chapter  
3 55 of title 10, United States  
4 Code, or title 38, United States  
5 Code, or any other provision of  
6 law, and other than payments  
7 made under title XIX in a State  
8 in which no medical home or al-  
9 ternative payment model is avail-  
10 able under the State program  
11 under that title),  
12 meet the requirement described in  
13 clause (iii)(I) with respect to pay-  
14 ments described in item (aa) and meet  
15 the requirement described in clause  
16 (iii)(II) with respect to payments de-  
17 scribed in item (bb);  
18 “(II) for whom the Secretary de-  
19 termines at least 25 percent of pay-  
20 ments under this part for covered pro-  
21 fessional services furnished by such  
22 professional during the most recent  
23 period for which data are available  
24 (which may be less than a year) were  
25 attributable to such services furnished

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 law, and other than payments  
2 made under title XIX in a State  
3 in which no medical home or al-  
4 ternative payment model is avail-  
5 able under the State program  
6 under that title),  
7 meet the requirement described in  
8 clause (iii)(I) with respect to pay-  
9 ments described in item (aa) and meet  
10 the requirement described in clause  
11 (iii)(II) with respect to payments de-  
12 scribed in item (bb);  
13 “(II) for whom the Secretary de-  
14 termines at least 25 percent of pay-  
15 ments under this part for covered pro-  
16 fessional services furnished by such  
17 professional during the most recent  
18 period for which data are available  
19 (which may be less than a year) were  
20 attributable to such services furnished  
21 under this part through an entity that  
22 participates in an eligible alternative  
23 payment model with respect to such  
24 services; and

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24          (f) IMPROVING PAYMENT ACCURACY.—

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

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

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

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

6 (B) STUDY USING OTHER DATA.—

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

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



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

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

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

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

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

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

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

(2) CMS ACTIVITIES.—

(A) 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

specific clinical criteria and patient characteristics to classify patients into—

“(i) care episode groups; and

“(ii) patient condition groups.

“(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

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

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

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

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

8 “(iii) PATIENT CONDITION GROUPS.—  
9 In establishing the patient condition  
10 groups under clause (i), the Secretary shall  
11 take into account—

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 “(C) MEASUREMENT OF RESOURCE USE.—

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4                   “(i) Clinical care.

5                   “(ii) Safety.

6                   “(iii) Care coordination.

7                   “(iv) Patient and caregiver experience.

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

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

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

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

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

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

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

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

7                   “(ii) Patient experience measures.

8                   “(iii) Care coordination measures.

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

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

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

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

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

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

13          “(B) PRIORITIZATION.—

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

13               “(A) Subsection (q)(2)(B)(i).

14               “(B) Section 1833(z)(2)(C).

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

1 **SEC. 103. ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.**  
 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) EDUCATION AND OUTREACH.—

(1) CAMPAIGN.—

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

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

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

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

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

13 (2) REPORT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

9 “(III) Electronic health records.

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

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

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

1 “(II) THRESHOLDS FOR USE.—

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

9 “(III) DISCLOSURE OF INFORMA-  
10 TION.—The Secretary shall make ag-  
11 gregate information available under  
12 this subparagraph but shall not dis-  
13 close information in a form or manner  
14 that identifies an eligible professional  
15 or a group practice, or information  
16 collected or obtained pursuant to a  
17 nondisclosure agreement.

18 “(vi) INCENTIVE TO PARTICIPATE.—

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

provided in a form and manner specified  
by the Secretary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

9            (B) in subparagraph (K)(iii)(VI)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 “(ii) Payment locality 3.

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

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

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



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

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

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

7 “(1) PROGRAM ESTABLISHED.—

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

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

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

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

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

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

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

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

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

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

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

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

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

24 “(i) have stakeholder consensus;

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

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

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

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

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

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

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

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

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

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

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

1 available from medical specialty orga-  
2 nizations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

20 “(ii) Information regarding—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1       2017, the Secretary shall determine, on an an-  
2       nual basis, no more than five percent of the  
3       total number of ordering professionals who are  
4       outlier ordering professionals.

5               “(B)   OUTLIER   ORDERING   PROFES-  
6       SIONALS.—The determination of an outlier or-  
7       dering professional shall—

8               “(i) be based on low adherence to ap-  
9       plicable appropriate use criteria specified  
10      under paragraph (2), which may be based  
11      on comparison to other ordering profes-  
12      sionals; and

13              “(ii) include data for ordering profes-  
14      sionals for whom prior authorization under  
15      paragraph (6)(A) applies.

16              “(C) USE OF TWO YEARS OF DATA.—The  
17      Secretary shall use two years of data to identify  
18      outlier ordering professionals under this para-  
19      graph.

20              “(D) PROCESS.—The Secretary shall es-  
21      tablish a process for determining when an  
22      outlier ordering professional is no longer an  
23      outlier ordering professional.

24              “(E)   CONSULTATION   WITH   STAKE-  
25      HOLDERS.—The Secretary shall consult with

1 physicians, practitioners and other stakeholders  
2 in developing methods to identify outlier order-  
3 ing professionals under this paragraph.

4 “(6) PRIOR AUTHORIZATION FOR ORDERING  
5 PROFESSIONALS WHO ARE OUTLIERS.—

6 “(A) IN GENERAL.—Beginning not later  
7 than January 1, 2020, subject to paragraph  
8 (4)(C), with respect to services furnished during  
9 a year, the Secretary shall, for a period deter-  
10 mined appropriate by the Secretary, apply prior  
11 authorization for applicable imaging services  
12 that are ordered by an outlier ordering profes-  
13 sional identified under paragraph (5).

14 “(B) APPROPRIATE USE CRITERIA IN  
15 PRIOR AUTHORIZATION.—In applying prior au-  
16 thorization under subparagraph (A), the Sec-  
17 retary shall utilize only the applicable appro-  
18 priate use criteria specified under this sub-  
19 section.

20 “(C) FUNDING.—For purposes of carrying  
21 out this paragraph, the Secretary shall provide  
22 for the transfer, from the Federal Supple-  
23 mentary Medical Insurance Trust Fund under  
24 section 1841, of \$5,000,000 to the Centers for  
25 Medicare & Medicaid Services Program Man-

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

5           “(7) CONSTRUCTION.—Nothing in this sub-  
 6           section shall be construed as granting the Secretary  
 7           the authority to develop or initiate the development  
 8           of clinical practice guidelines or appropriate use cri-  
 9           teria.”.

10          (b)           CONFORMING           AMENDMENT.—Section  
 11   1833(t)(16) of the Social Security Act (42 U.S.C.  
 12   1395l(t)(16)) is amended by adding at the end the fol-  
 13   lowing new subparagraph:

14                   “(E) APPLICATION OF APPROPRIATE USE  
 15                   CRITERIA FOR CERTAIN IMAGING SERVICES.—  
 16                   For provisions relating to the application of ap-  
 17                   propriate use criteria for certain imaging serv-  
 18                   ices, see section 1834(p).”.

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

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

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

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

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

12 (1) Information on the number of services fur-  
13 nished by the eligible professional under part B of  
14 title XVIII of the Social Security Act (42 U.S.C.  
15 1395j et seq.), which may include information on the  
16 most frequent services furnished or groupings of  
17 services.

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

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

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

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

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

5           (3) The location of the eligible professional.

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

12          (e) IMPLEMENTATION.—

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

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

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

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

24           (f) OPPORTUNITY TO REVIEW AND SUBMIT CORREC-  
25          TIONS.—The Secretary shall provide for an opportunity



1 for an eligible professional to review, and submit correc-  
 2 tions for, the information to be made public with respect  
 3 to the eligible professional under this section prior to such  
 4 information being made public.

5 (g) DEFINITIONS.—In this section:

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

10 (2) PHYSICIAN COMPARE.—The term “Physi-  
 11 cian Compare” means the Physician Compare Inter-  
 12 net website of the Centers for Medicare & Medicaid  
 13 Services (or a successor website).

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

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

17 (1) ADDITIONAL ANALYSES.—

18 (A) IN GENERAL.—Subject to subpara-  
 19 graph (B), to the extent consistent with appli-  
 20 cable information, privacy, security, and disclo-  
 21 sure laws (including paragraph (3)), notwith-  
 22 standing paragraph (4)(B) of section 1874(e) of  
 23 the Social Security Act (42 U.S.C. 1395kk(e))  
 24 and the second sentence of paragraph (4)(D) of  
 25 such section, beginning July 1, 2015, a quali-

1       fied entity may use the combined data described  
2       in paragraph (4)(B)(iii) of such section received  
3       by such entity under such section, and informa-  
4       tion derived from the evaluation described in  
5       such paragraph (4)(D), to conduct additional  
6       non-public analyses (as determined appropriate  
7       by the Secretary) and provide or sell such anal-  
8       yses to authorized users for non-public use (in-  
9       cluding for the purposes of assisting providers  
10      of services and suppliers to develop and partici-  
11      pate in quality and patient care improvement  
12      activities, including developing new models of  
13      care).

14               (B) LIMITATIONS WITH RESPECT TO ANAL-  
15      YSES.—

16               (i) EMPLOYERS.—Any analyses pro-  
17      vided or sold under subparagraph (A) to  
18      an employer described in paragraph  
19      (9)(A)(iii) may only be used by such em-  
20      ployer for purposes of providing health in-  
21      surance to employees and retirees of the  
22      employer.

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

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

(2) ACCESS TO CERTAIN DATA.—

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

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

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

cluding for the purposes described in subparagraph (B).

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

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

(3) PROTECTION OF INFORMATION.—

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

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

1 ually identifies a patient of such provider or  
2 supplier, including with respect to items and  
3 services furnished to the patient by other pro-  
4 viders of services or suppliers.

5 (C) PROHIBITION ON USING ANALYSES OR  
6 DATA FOR MARKETING PURPOSES.—An author-  
7 ized user shall not use an analysis or data pro-  
8 vided or sold under paragraph (1) or (2) for  
9 marketing purposes.

10 (4) DATA USE AGREEMENT.—A qualified entity  
11 and an authorized user described in clauses (i), (ii),  
12 and (v) of paragraph (9)(A) shall enter into an  
13 agreement regarding the use of any data that the  
14 qualified entity is providing or selling to the author-  
15 ized user under paragraph (2). Such agreement shall  
16 describe the requirements for privacy and security of  
17 the data and, as determined appropriate by the Sec-  
18 retary, any prohibitions on using such data to link  
19 to other individually identifiable sources of informa-  
20 tion. If the authorized user is not a covered entity  
21 under the rules promulgated pursuant to the Health  
22 Insurance Portability and Accountability Act of  
23 1996, the agreement shall identify the relevant regu-  
24 lations, as determined by the Secretary, that the

1 user shall comply with as if it were acting in the ca-  
2 pacity of such a covered entity.

3 (5) NO REDISCLOSURE OF ANALYSES OR  
4 DATA.—

5 (A) IN GENERAL.—Except as provided in  
6 subparagraph (B), an authorized user that is  
7 provided or sold an analysis or data under  
8 paragraph (1) or (2) shall not redisclose or  
9 make public such analysis or data or any anal-  
10 ysis using such data.

11 (B) PERMITTED REDISCLOSURE.—A pro-  
12 vider of services or supplier that is provided or  
13 sold an analysis or data under paragraph (1) or  
14 (2) may, as determined by the Secretary, redis-  
15 close such analysis or data for the purposes of  
16 performance improvement and care coordination  
17 activities but shall not make public such anal-  
18 ysis or data or any analysis using such data.

19 (6) OPPORTUNITY FOR PROVIDERS OF SERV-  
20 ICES AND SUPPLIERS TO REVIEW.—Prior to a quali-  
21 fied entity providing or selling an analysis to an au-  
22 thorized user under paragraph (1), to the extent  
23 that such analysis would individually identify a pro-  
24 vider of services or supplier who is not being pro-  
25 vided or sold such analysis, such qualified entity

1 shall provide such provider or supplier with the op-  
 2 portunity to appeal and correct errors in the manner  
 3 described in section 1874(e)(4)(C)(ii) of the Social  
 4 Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

5 (7) ASSESSMENT FOR A BREACH.—

6 (A) IN GENERAL.—In the case of a breach  
 7 of a data use agreement under this section or  
 8 section 1874(e) of the Social Security Act (42  
 9 U.S.C. 1395kk(e)), the Secretary shall impose  
 10 an assessment on the qualified entity both in  
 11 the case of—

12 (i) an agreement between the Sec-  
 13 retary and a qualified entity; and

14 (ii) an agreement between a qualified  
 15 entity and an authorized user.

16 (B) ASSESSMENT.—The assessment under  
 17 subparagraph (A) shall be an amount up to  
 18 \$100 for each individual entitled to, or enrolled  
 19 for, benefits under part A of title XVIII of the  
 20 Social Security Act or enrolled for benefits  
 21 under part B of such title—

22 (i) in the case of an agreement de-  
 23 scribed in subparagraph (A)(i), for whom  
 24 the Secretary provided data on to the  
 25 qualified entity under paragraph (2); and

(ii) in the case of an agreement described in subparagraph (A)(ii), for whom the qualified entity provided data on to the authorized user under paragraph (2).

(C) DEPOSIT OF AMOUNTS COLLECTED.—

Any amounts collected pursuant to this paragraph shall be deposited in Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

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

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

(B) a description of the topics and purposes of such analyses;

(C) information on the entities who received the data under paragraph (2), the uses of the data, and the total amount of fees received for providing, selling, or sharing the data; and



1 (D) other information determined appro-  
2 priate by the Secretary.

3 (9) DEFINITIONS.—In this subsection and sub-  
4 section (b):

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

7 (i) A provider of services.

8 (ii) A supplier.

9 (iii) An employer (as defined in sec-  
10 tion 3(5) of the Employee Retirement In-  
11 surance Security Act of 1974).

12 (iv) A health insurance issuer (as de-  
13 fined in section 2791 of the Public Health  
14 Service Act).

15 (v) A medical society or hospital asso-  
16 ciation.

17 (vi) Any entity not described in  
18 clauses (i) through (v) that is approved by  
19 the Secretary (other than an employer or  
20 health insurance issuer not described in  
21 clauses (iii) and (iv), respectively, as deter-  
22 mined by the Secretary).

23 (B) PROVIDER OF SERVICES.—The term  
24 “provider of services” has the meaning given

1 such term in section 1861(u) of the Social Se-  
 2 curity Act (42 U.S.C. 1395x(u)).

3 (C) QUALIFIED ENTITY.—The term “quali-  
 4 fied entity” has the meaning given such term in  
 5 section 1874(e)(2) of the Social Security Act  
 6 (42 U.S.C. 1395kk(e)).

7 (D) SECRETARY.—The term “Secretary”  
 8 means the Secretary of Health and Human  
 9 Services.

10 (E) SUPPLIER.—The term “supplier” has  
 11 the meaning given such term in section 1861(d)  
 12 of the Social Security Act (42 U.S.C.  
 13 1395x(d)).

14 (b) ACCESS TO MEDICARE DATA BY QUALIFIED  
 15 CLINICAL DATA REGISTRIES TO FACILITATE QUALITY  
 16 IMPROVEMENT.—

17 (1) ACCESS.—

18 (A) IN GENERAL.—To the extent con-  
 19 sistent with applicable information, privacy, se-  
 20 curity, and disclosure laws, beginning July 1,  
 21 2015, the Secretary shall, at the request of a  
 22 qualified clinical data registry under section  
 23 1848(m)(3)(E) of the Social Security Act (42  
 24 U.S.C. 1395w-4(m)(3)(E)), provide the data  
 25 described in subparagraph (B) (in a form and

1 manner determined to be appropriate) to such  
2 qualified clinical data registry for purposes of  
3 linking such data with clinical outcomes data  
4 and performing risk-adjusted, scientifically valid  
5 analyses and research to support quality im-  
6 provement or patient safety, provided that any  
7 public reporting of such analyses or research  
8 that identifies a provider of services or supplier  
9 shall only be conducted with the opportunity of  
10 such provider or supplier to appeal and correct  
11 errors in the manner described in subsection  
12 (a)(6).

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

15 (i) claims data under the Medicare  
16 program under title XVIII of the Social  
17 Security Act; and

18 (ii) if the Secretary determines appro-  
19 priate, claims data under the Medicaid  
20 program under title XIX of such Act and  
21 the State Children’s Health Insurance Pro-  
22 gram under title XXI of such Act.

23 (2) FEE.—Data described in paragraph (1)(B)  
24 shall be provided to a qualified clinical data registry  
25 under paragraph (1) at a fee equal to the cost of

1 providing such data. Any fee collected pursuant to  
 2 the preceding sentence shall be deposited in the Cen-  
 3 ters for Medicare & Medicaid Services Program  
 4 Management Account.

5 (c) EXPANSION OF DATA AVAILABLE TO QUALIFIED  
 6 ENTITIES.—Section 1874(e) of the Social Security Act  
 7 (42 U.S.C. 1395kk(e)) is amended—

8 (1) in the subsection heading, by striking  
 9 “MEDICARE”; and

10 (2) in paragraph (3)—

11 (A) by inserting after the first sentence the  
 12 following new sentence: “Beginning July 1,  
 13 2015, if the Secretary determines appropriate,  
 14 the data described in this paragraph may also  
 15 include standardized extracts (as determined by  
 16 the Secretary) of claims data under titles XIX  
 17 and XXI for assistance provided under such ti-  
 18 tles for one or more specified geographic areas  
 19 and time periods requested by a qualified enti-  
 20 ty.”; and

21 (B) in the last sentence, by inserting “or  
 22 under titles XIX or XXI” before the period at  
 23 the end.

1 (d) REVISION OF PLACEMENT OF FEES.—Section  
 2 1874(e)(4)(A) of the Social Security Act (42 U.S.C.  
 3 1395kk(e)(4)(A)) is amended, in the second sentence—

4 (1) by inserting “, for periods prior to July 1,  
 5 2015,” after “deposited”; and

6 (2) by inserting the following before the period  
 7 at the end: “, and, beginning July 1, 2015, into the  
 8 Centers for Medicare & Medicaid Services Program  
 9 Management Account”.

10 **SEC. 108. REDUCING ADMINISTRATIVE BURDEN AND**  
 11 **OTHER PROVISIONS.**

12 (a) MEDICARE PHYSICIAN AND PRACTITIONER OPT-  
 13 OUT TO PRIVATE CONTRACT.—

14 (1) INDEFINITE, CONTINUING AUTOMATIC EX-  
 15 TENSION OF OPT OUT ELECTION.—

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

19 (i) in subparagraph (B)(ii), by strik-  
 20 ing “during the 2-year period beginning on  
 21 the date the affidavit is signed” and insert-  
 22 ing “during the applicable 2-year period  
 23 (as defined in subparagraph (D))”;

24 (ii) in subparagraph (C), by striking  
 25 “during the 2-year period described in sub-

1 paragraph (B)(ii)” and inserting “during  
2 the applicable 2-year period”; and

3 (iii) by adding at the end the fol-  
4 lowing new subparagraph:

5 “(D) APPLICABLE 2-YEAR PERIODS FOR  
6 EFFECTIVENESS OF AFFIDAVITS.—In this sub-  
7 section, the term ‘applicable 2-year period’  
8 means, with respect to an affidavit of a physi-  
9 cian or practitioner under subparagraph (B),  
10 the 2-year period beginning on the date the af-  
11 fidavit is signed and includes each subsequent  
12 2-year period unless the physician or practi-  
13 tioner involved provides notice to the Secretary  
14 (in a form and manner specified by the Sec-  
15 retary), not later than 30 days before the end  
16 of the previous 2-year period, that the physician  
17 or practitioner does not want to extend the ap-  
18 plication of the affidavit for such subsequent 2-  
19 year period.”.

20 (B) EFFECTIVE DATE.—The amendments  
21 made by subparagraph (A) shall apply to affi-  
22 davits entered into on or after the date that is  
23 60 days after the date of the enactment of this  
24 Act.

1           (2) PUBLIC AVAILABILITY OF INFORMATION ON  
2           OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section  
3           1802(b) of the Social Security Act (42 U.S.C.  
4           1395a(b)) is amended—

5                   (A) in paragraph (5), by adding at the end  
6           the following new subparagraph:

7                   “(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—  
8           The term ‘opt-out physician or practitioner’ means  
9           a physician or practitioner who has in effect an affi-  
10          davit under paragraph (3)(B).”;

11                   (B) by redesignating paragraph (5) as  
12          paragraph (6); and

13                   (C) by inserting after paragraph (4) the  
14          following new paragraph:

15                   “(5) POSTING OF INFORMATION ON OPT-OUT  
16          PHYSICIANS AND PRACTITIONERS.—

17                   “(A) IN GENERAL.—Beginning not later  
18          than February 1, 2015, the Secretary shall  
19          make publicly available through an appropriate  
20          publicly accessible website of the Department of  
21          Health and Human Services information on the  
22          number and characteristics of opt-out physi-  
23          cians and practitioners and shall update such  
24          information on such website not less often than  
25          annually.

1 “(B) INFORMATION TO BE INCLUDED.—

2 The information to be made available under  
3 subparagraph (A) shall include at least the fol-  
4 lowing with respect to opt-out physicians and  
5 practitioners:

6 “(i) Their number.

7 “(ii) Their physician or professional  
8 specialty or other designation.

9 “(iii) Their geographic distribution.

10 “(iv) The timing of their becoming  
11 opt-out physicians and practitioners, rel-  
12 ative to when they first entered practice  
13 and with respect to applicable 2-year peri-  
14 ods.

15 “(v) The proportion of such physi-  
16 cians and practitioners who billed for  
17 emergency or urgent care services.”.

18 (b) GAINSHARING STUDY AND REPORT.—Not later  
19 than 6 months after the date of the enactment of this Act,  
20 the Secretary of Health and Human Services, in consulta-  
21 tion with the Inspector General of the Department of  
22 Health and Human Services, shall submit to Congress a  
23 report with legislative recommendations to amend existing  
24 fraud and abuse laws, through exceptions, safe harbors,  
25 or other narrowly targeted provisions, to permit



1 gainsharing or similar arrangements between physicians  
2 and hospitals that improve care while reducing waste and  
3 increasing efficiency. The report shall—

4 (1) consider whether such provisions should  
5 apply to ownership interests, compensation arrange-  
6 ments, or other relationships;

7 (2) describe how the recommendations address  
8 accountability, transparency, and quality, including  
9 how best to limit inducements to stint on care, dis-  
10 charge patients prematurely, or otherwise reduce or  
11 limit medically necessary care; and

12 (3) consider whether a portion of any savings  
13 generated by such arrangements should accrue to  
14 the Medicare program under title XVIII of the So-  
15 cial Security Act.

16 (c) PROMOTING INTEROPERABILITY OF ELECTRONIC  
17 HEALTH RECORD SYSTEMS.—

18 (1) RECOMMENDATIONS FOR ACHIEVING WIDE-  
19 SPREAD EHR INTEROPERABILITY.—

20 (A) OBJECTIVE.—As a consequence of a  
21 significant Federal investment in the implemen-  
22 tation of health information technology through  
23 the Medicare and Medicaid EHR incentive pro-  
24 grams, Congress declares it a national objective  
25 to achieve widespread exchange of health infor-

1 mation through interoperable certified EHR  
2 technology nationwide by December 31, 2017.

3 (B) DEFINITIONS.—In this paragraph:

4 (i) WIDESPREAD INTEROPER-  
5 ABILITY.—The term “widespread inter-  
6 operability” means interoperability between  
7 certified EHR technology systems em-  
8 ployed by meaningful EHR users under  
9 the Medicare and Medicaid EHR incentive  
10 programs and other clinicians and health  
11 care providers on a nationwide basis.

12 (ii) INTEROPERABILITY.—The term  
13 “interoperability” means the ability of two  
14 or more health information systems or  
15 components to exchange clinical and other  
16 information and to use the information  
17 that has been exchanged using common  
18 standards as to provide access to longitu-  
19 dinal information for health care providers  
20 in order to facilitate coordinated care and  
21 improved patient outcomes.

22 (C) ESTABLISHMENT OF METRICS.—Not  
23 later than July 1, 2015, and in consultation  
24 with stakeholders, the Secretary shall establish  
25 metrics to be used to determine if and to the

1 extent that the objective described in subpara-  
 2 graph (A) has been achieved.

3 (D) RECOMMENDATIONS IF OBJECTIVE  
 4 NOT ACHIEVED.—If the Secretary of Health  
 5 and Human Services determines that the objec-  
 6 tive described in subparagraph (A) has not been  
 7 achieved by December 31, 2017, then the Sec-  
 8 retary shall submit to Congress a report, by not  
 9 later than December 31, 2018, that identifies  
 10 barriers to such objective and recommends ac-  
 11 tions that the Federal Government can take to  
 12 achieve such objective. Such recommended ac-  
 13 tions may include recommendations—

14 (i) to adjust payments for not being  
 15 meaningful EHR users under the Medicare  
 16 EHR incentive programs; and

17 (ii) for criteria for decertifying cer-  
 18 tified EHR technology products.

19 (2) PREVENTING BLOCKING THE SHARING OF  
 20 INFORMATION.—

21 (A) FOR MEANINGFUL EHR PROFES-  
 22 SIONALS.—Section 1848(o)(2)(A)(ii) of the So-  
 23 cial Security Act (42 U.S.C. 1395w-  
 24 4(o)(2)(A)(ii)) is amended by inserting before  
 25 the period at the end the following: “, and the

1 professional demonstrates (through a process  
 2 specified by the Secretary, such as the use of an  
 3 attestation) that the professional has not know-  
 4 ingly and willfully taken any action to limit or  
 5 restrict the compatibility or interoperability of  
 6 the certified EHR technology”.

7 (B) FOR MEANINGFUL EHR HOSPITALS.—  
 8 Section 1886(n)(3)(A)(ii) of the Social Security  
 9 Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amend-  
 10 ed by inserting before the period at the end the  
 11 following: “, and the hospital demonstrates  
 12 (through a process specified by the Secretary,  
 13 such as the use of an attestation) that the hos-  
 14 pital has not knowingly and willfully taken any  
 15 action to limit or restrict the compatibility or  
 16 interoperability of the certified EHR tech-  
 17 nology”.

18 (C) EFFECTIVE DATE.—The amendments  
 19 made by this subsection shall apply to meaning-  
 20 ful EHR users as of the date that is one year  
 21 after the date of the enactment of this Act.

22 (3) STUDY AND REPORT ON THE FEASIBILITY  
 23 OF ESTABLISHING A WEBSITE TO COMPARE CER-  
 24 TIFIED EHR TECHNOLOGY PRODUCTS.—

1           (A) STUDY.—The Secretary shall conduct  
2           a study to examine the feasibility of estab-  
3           lishing mechanisms that includes aggregated re-  
4           sults of surveys of meaningful EHR users on  
5           the functionality of certified EHR technology  
6           products to enable such users to directly com-  
7           pare the functionality and other features of  
8           such products. Such information may be made  
9           available through contracts with physician, hos-  
10          pital, or other organizations that maintain such  
11          comparative information.

12          (B) REPORT.—Not later than 1 year after  
13          the date of the enactment of this Act, the Sec-  
14          retary shall submit to Congress a report on the  
15          website. The report shall include information on  
16          the benefits of, and resources needed to develop  
17          and maintain, such a website.

18          (4) DEFINITIONS.—In this subsection:

19               (A) The term “certified EHR technology”  
20               has the meaning given such term in section  
21               1848(o)(4) of the Social Security Act (42  
22               U.S.C. 1395w–4(o)(4)).

23               (B) The term “meaningful EHR user” has  
24               the meaning given such term under the Medi-  
25               care EHR incentive programs.

(C) The term “Medicare and Medicaid EHR incentive programs” means—

(i) in the case of the Medicare program under title XVIII of the Social Security Act, the incentive programs under section 1814(l)(3), section 1848(o), subsections (l) and (m) of section 1853, and section 1886(n) of the Social Security Act (42 U.S.C. 1395f(l)(3), 1395w-4(o), 1395w-23, 1395ww(n)); and

(ii) in the case of the Medicaid program under title XIX of such Act, the incentive program under subsections (a)(3)(F) and (t) of section 1903 of such Act (42 U.S.C. 1396b).

(D) The term “Secretary” means the Secretary of Health and Human Services.

(d) GAO STUDIES AND REPORTS ON THE USE OF TELEHEALTH UNDER FEDERAL PROGRAMS AND ON REMOTE PATIENT MONITORING SERVICES.—

(1) STUDY ON TELEHEALTH SERVICES.—The Comptroller General of the United States shall conduct a study on the following:

(A) How the definition of telehealth across various Federal programs and Federal efforts

1 can inform the use of telehealth in the Medicare  
2 program under title XVIII of the Social Secu-  
3 rity Act (42 U.S.C. 1395 et seq.).

4 (B) Issues that can facilitate or inhibit the  
5 use of telehealth under the Medicare program  
6 under such title, including oversight and profes-  
7 sional licensure, changing technology, privacy  
8 and security, infrastructure requirements, and  
9 varying needs across urban and rural areas.

10 (C) Potential implications of greater use of  
11 telehealth with respect to payment and delivery  
12 system transformations under the Medicare  
13 program under such title XVIII and the Med-  
14 icaid program under title XIX of such Act (42  
15 U.S.C. 1396 et seq.).

16 (D) How the Centers for Medicare & Med-  
17 icaid Services conducts oversight of payments  
18 made under the Medicare program under such  
19 title XVIII to providers for telehealth services.

20 (2) STUDY ON REMOTE PATIENT MONITORING  
21 SERVICES.—

22 (A) IN GENERAL.—The Comptroller Gen-  
23 eral of the United States shall conduct a  
24 study—

1 (i) of the dissemination of remote pa-  
2 tient monitoring technology in the private  
3 health insurance market;

4 (ii) of the financial incentives in the  
5 private health insurance market relating to  
6 adoption of such technology;

7 (iii) of the barriers to adoption of  
8 such services under the Medicare program  
9 under title XVIII of the Social Security  
10 Act;

11 (iv) that evaluates the patients, condi-  
12 tions, and clinical circumstances that could  
13 most benefit from remote patient moni-  
14 toring services; and

15 (v) that evaluates the challenges re-  
16 lated to establishing appropriate valuation  
17 for remote patient monitoring services  
18 under the Medicare physician fee schedule  
19 under section 1848 of the Social Security  
20 Act (42 U.S.C. 1395w-4) in order to accu-  
21 rately reflect the resources involved in fur-  
22 nishing such services.

23 (B) DEFINITIONS.—For purposes of this  
24 paragraph:



1 (i) REMOTE PATIENT MONITORING  
2 SERVICES.—The term “remote patient  
3 monitoring services” means services fur-  
4 nished through remote patient monitoring  
5 technology.

6 (ii) REMOTE PATIENT MONITORING  
7 TECHNOLOGY.—The term “remote patient  
8 monitoring technology” means a coordi-  
9 nated system that uses one or more home-  
10 based or mobile monitoring devices that  
11 automatically transmit vital sign data or  
12 information on activities of daily living and  
13 may include responses to assessment ques-  
14 tions collected on the devices wirelessly or  
15 through a telecommunications connection  
16 to a server that complies with the Federal  
17 regulations (concerning the privacy of indi-  
18 vidually identifiable health information)  
19 promulgated under section 264(c) of the  
20 Health Insurance Portability and Account-  
21 ability Act of 1996, as part of an estab-  
22 lished plan of care for that patient that in-  
23 cludes the review and interpretation of that  
24 data by a health care professional.

1           (3) REPORTS.—Not later than 24 months after  
2           the date of the enactment of this Act, the Comp-  
3           troller General shall submit to Congress—

4                   (A) a report containing the results of the  
5                   study conducted under paragraph (1); and

6                   (B) a report containing the results of the  
7                   study conducted under paragraph (2).

8           A report required under this paragraph shall be sub-  
9           mitted together with recommendations for such leg-  
10          islation and administrative action as the Comptroller  
11          General determines appropriate. The Comptroller  
12          General may submit one report containing the re-  
13          sults described in subparagraphs (A) and (B) and  
14          the recommendations described in the previous sen-  
15          tence.

16          (e)    RULE    OF    CONSTRUCTION    REGARDING  
17   HEALTHCARE PROVIDER STANDARDS OF CARE.—

18               (1) MAINTENANCE OF STATE STANDARDS.—

19          The development, recognition, or implementation of  
20          any guideline or other standard under any Federal  
21          health care provision shall not be construed—

22                   (A) to establish the standard of care or  
23                   duty of care owed by a health care provider to  
24                   a patient in any medical malpractice or medical  
25                   product liability action or claim; or

1 (B) to preempt any standard of care or  
 2 duty of care, owed by a health care provider to  
 3 a patient, duly established under State or com-  
 4 mon law.

5 (2) DEFINITIONS.—For purposes of this sub-  
 6 section:

7 (A) FEDERAL HEALTH CARE PROVISION.—  
 8 The term “Federal health care provision”  
 9 means any provision of the Patient Protection  
 10 and Affordable Care Act (Public Law 111–  
 11 148), title I or subtitle B of title II of the  
 12 Health Care and Education Reconciliation Act  
 13 of 2010 (Public Law 111–152), or title XVIII  
 14 or XIX of the Social Security Act.

15 (B) HEALTH CARE PROVIDER.—The term  
 16 “health care provider” means any individual or  
 17 entity—

18 (i) licensed, registered, or certified  
 19 under Federal or State laws or regulations  
 20 to provide health care services; or

21 (ii) required to be so licensed, reg-  
 22 istered, or certified but that is exempted  
 23 by other statute or regulation.

24 (C) MEDICAL MALPRACTICE OR MEDICAL  
 25 PRODUCT LIABILITY ACTION OR CLAIM.—The

term “medical malpractice or medical product liability action or claim” means a medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))) and includes a liability action or claim relating to a health care provider’s prescription or provision of a drug, device, or biological product (as such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act).

(D) STATE.—The term “State” includes the District of Columbia, Puerto Rico, and any other commonwealth, possession, or territory of the United States.

(3) PRESERVATION OF STATE LAW.—No provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.

1           **TITLE II—EXTENSIONS**  
 2           **Subtitle A—Medicare Extensions**

3   **SEC. 201. WORK GEOGRAPHIC ADJUSTMENT.**

4           Section 1848(e)(1)(E) of the Social Security Act (42  
 5 U.S.C. 1395w–4(e)(1)(E)) is amended by striking “and  
 6 before April 1, 2014,”.

7   **SEC. 202. MEDICARE PAYMENT FOR THERAPY SERVICES.**

8           (a) REPEAL OF THERAPY CAP AND 1-YEAR EXTEN-  
 9 SION OF THRESHOLD FOR MANUAL MEDICAL REVIEW.—  
 10 Section 1833(g) of the Social Security Act (42 U.S.C.  
 11 1395l(g)) is amended—

12           (1) in paragraph (4)—

13           (A) by striking “This subsection” and in-  
 14 serting “Except as provided in paragraph  
 15 (5)(C)(iii), this subsection”; and

16           (B) by inserting the following before the  
 17 period at the end: “or with respect to services  
 18 furnished on or after the date of enactment of  
 19 the Commonsense Medicare SGR Repeal and  
 20 Beneficiary Access Improvement Act of 2014”;  
 21 and

22           (2) in paragraph (5)(C), by adding at the end  
 23 the following new clause:

24           “(iii) Beginning on the date of enactment of the Com-  
 25 monsense Medicare SGR Repeal and Beneficiary Access

1 Improvement Act of 2014 and ending on the day before  
 2 the date that is 12 months after such date of enactment,  
 3 the manual medical review process described in clause (i)  
 4 shall apply with respect to expenses incurred in a year for  
 5 services described in paragraphs (1) and (3) that exceed  
 6 the threshold described in clause (ii) for the year.”.

7 (b) MEDICAL REVIEW OF OUTPATIENT THERAPY  
 8 SERVICES.—

9 (1) MEDICAL REVIEW OF OUTPATIENT THER-  
 10 APY SERVICES.—Section 1833 of the Social Security  
 11 Act (42 U.S.C. 1395l), as amended by section  
 12 101(e)(2), is amended by adding at the end the fol-  
 13 lowing new subsection:

14 “(aa) MEDICAL REVIEW OF OUTPATIENT THERAPY  
 15 SERVICES.—

16 “(1) IN GENERAL.—

17 “(A) PROCESS FOR MEDICAL REVIEW.—

18 The Secretary shall implement a process for the  
 19 medical review (as described in paragraph (2))  
 20 of outpatient therapy services (as defined in  
 21 paragraph (10)) and, subject to paragraph  
 22 (12), apply such process to such services fur-  
 23 nished on or after the date that is 12 months  
 24 after the date of enactment of the Common-  
 25 sense Medicare SGR Repeal and Beneficiary

1 Access Improvement Act of 2014, focusing on  
2 services identified under subparagraph (B).

3 “(B) IDENTIFICATION OF SERVICES FOR  
4 REVIEW.—Under the process, the Secretary  
5 shall identify services for medical review, using  
6 such factors as the Secretary determines appro-  
7 priate, which may include the following:

8 “(i) Services furnished by a therapy  
9 provider (as defined in paragraph (10))  
10 whose pattern of billing is aberrant com-  
11 pared to peers.

12 “(ii) Services furnished by a therapy  
13 provider who, in a prior period, has a high  
14 claims denial percentage or is less compli-  
15 ant with other applicable requirements  
16 under this title.

17 “(iii) Services furnished by a therapy  
18 provider that is newly enrolled under this  
19 title.

20 “(iv) Services furnished by a therapy  
21 provider who has questionable billing prac-  
22 tices, such as billing medically unlikely  
23 units of services in a day.

24 “(v) Services furnished to treat a type  
25 of medical condition.

1 “(vi) Services identified by use of the  
2 standardized data elements required to be  
3 reported under section 1834(p).

4 “(vii) Services furnished by a single  
5 therapy provider or a group that includes  
6 a therapy provider identified by factors de-  
7 scribed in this subparagraph.

8 “(viii) Other services as determined  
9 appropriate by the Secretary.

10 “(2) MEDICAL REVIEW.—

11 “(A) PRIOR AUTHORIZATION MEDICAL RE-  
12 VIEW.—

13 “(i) IN GENERAL.—Subject to the  
14 succeeding provisions of this subparagraph,  
15 the Secretary shall use prior authorization  
16 medical review for outpatient therapy serv-  
17 ices furnished to an individual above one  
18 or more thresholds established by the Sec-  
19 retary, such as a dollar threshold or a  
20 threshold based on other factors.

21 “(ii) ENDING APPLICATION OF PRIOR  
22 AUTHORIZATION FOR A THERAPY PRO-  
23 VIDER.—The Secretary shall end the appli-  
24 cation of prior authorization medical re-  
25 view to outpatient therapy services fur-



1           nished by a therapy provider if the Sec-  
2           retary determines that the provider has a  
3           low denial rate under such prior authoriza-  
4           tion. The Secretary may subsequently re-  
5           apply prior authorization medical review to  
6           such therapy provider if the Secretary de-  
7           termines it to be appropriate.

8           “(iii) PRIOR AUTHORIZATION OF MUL-  
9           TIPLE SERVICES.—The Secretary shall,  
10          where practicable, provide for prior author-  
11          ization medical review for multiple services  
12          at a single time, such as services in a ther-  
13          apy plan of care described in section  
14          1861(p)(2).

15          “(B) OTHER TYPES OF MEDICAL RE-  
16          VIEW.—The Secretary may use pre-payment re-  
17          view or post-payment review for services identi-  
18          fied under paragraph (1)(B) that are not sub-  
19          ject to prior authorization medical review under  
20          subparagraph (A).

21          “(C) LIMITATION FOR LAW ENFORCEMENT  
22          ACTIVITIES.—The Secretary may determine  
23          that medical review under this subsection does  
24          not apply in the case where potential fraud may  
25          be involved.

1           “(3) REVIEW CONTRACTORS.—The Secretary  
2           shall conduct prior authorization medical review of  
3           outpatient therapy services under this subsection  
4           using medicare administrative contractors (as de-  
5           scribed in section 1874A) or other review contrac-  
6           tors (other than contractors under section 1893(h)  
7           or contractors paid on a contingent basis).

8           “(4) NO PAYMENT WITHOUT PRIOR AUTHORIZA-  
9           TION.—With respect to an outpatient therapy service  
10          for which prior authorization medical review under  
11          this subsection applies, the following shall apply:

12                 “(A) PRIOR AUTHORIZATION DETERMINA-  
13                 TION.—The Secretary shall make a determina-  
14                 tion, prior to the service being furnished, of  
15                 whether the service would or would not meet  
16                 the applicable requirements of section  
17                 1862(a)(1)(A).

18                 “(B) DENIAL OF PAYMENT.—Subject to  
19                 paragraph (6), no payment shall be made under  
20                 this part for the service unless the Secretary  
21                 determines pursuant to subparagraph (A) that  
22                 the service would meet the applicable require-  
23                 ments of such section.

24           “(5) SUBMISSION OF INFORMATION.—A ther-  
25          apy provider may submit the information necessary

1 for medical review by fax, by mail, or by electronic  
2 means. The Secretary shall make available the elec-  
3 tronic means described in the preceding sentence as  
4 soon as practicable, but not later than 24 months  
5 after the date of enactment of this subsection.

6 “(6) TIMELINESS.—If the Secretary does not  
7 make a prior authorization determination under  
8 paragraph (4)(A) within 10 business days of the  
9 date of the Secretary’s receipt of medical docu-  
10 mentation needed to make such determination, para-  
11 graph (4)(B) shall not apply.

12 “(7) CONSTRUCTION.—With respect to an out-  
13 patient therapy service that has been affirmed by  
14 medical review under this subsection, nothing in this  
15 subsection shall be construed to preclude the subse-  
16 quent denial of a claim for such service that does  
17 not meet other applicable requirements under this  
18 Act.

19 “(8) BENEFICIARY PROTECTIONS.—With re-  
20 spect to services furnished on or after January 1,  
21 2015, where payment may not be made as a result  
22 of application of medical review under this sub-  
23 section, section 1879 shall apply in the same manner  
24 as such section applies to a denial that is made by  
25 reason of section 1862(a)(1).

1 “(9) IMPLEMENTATION.—

2 “(A) AUTHORITY.—The Secretary may im-  
3 plement the provisions of this subsection by in-  
4 terim final rule with comment period.

5 “(B) ADMINISTRATION.—Chapter 35 of  
6 title 44, United States Code, shall not apply to  
7 medical review under this subsection.

8 “(C) LIMITATION.—There shall be no ad-  
9 ministrative or judicial review under section  
10 1869, section 1878, or otherwise of the identi-  
11 fication of services for medical review or the  
12 process for medical review under this sub-  
13 section.

14 “(10) DEFINITIONS.—For purposes of this sub-  
15 section:

16 “(A) OUTPATIENT THERAPY SERVICES.—  
17 The term ‘outpatient therapy services’ means  
18 the following services for which payment is  
19 made under section 1848, 1834(g), or 1834(k):

20 “(i) Physical therapy services of the  
21 type described in section 1861(p).

22 “(ii) Speech-language pathology serv-  
23 ices of the type described in such section  
24 though the application of section  
25 1861(ll)(2).

1                   “(iii) Occupational therapy services of  
2                   the type described in section 1861(p)  
3                   through the operation of section 1861(g).

4                   “(B) THERAPY PROVIDER.—The term  
5                   ‘therapy provider’ means a provider of services  
6                   (as defined in section 1861(u)) or a supplier (as  
7                   defined in section 1861(d)) who submits a claim  
8                   for outpatient therapy services.

9                   “(11) FUNDING.—For purposes of imple-  
10                  menting this subsection, the Secretary shall provide  
11                  for the transfer, from the Federal Supplementary  
12                  Medical Insurance Trust Fund under section 1841,  
13                  of \$35,000,000 to the Centers for Medicare & Med-  
14                  icaid Services Program Management Account for  
15                  each fiscal year (beginning with fiscal year 2014).  
16                  Amounts transferred under this paragraph shall re-  
17                  main available until expended.

18                  “(12) SCALING BACK.—

19                  “(A) PERIODIC DETERMINATIONS.—Begin-  
20                  ning with 2017, and every two years thereafter,  
21                  the Secretary shall—

22                         “(i) make a determination of the im-  
23                         proper payment rate for outpatient therapy  
24                         services for a 12-month period; and

1 “(ii) make such determination publicly  
2 available.

3 “(B) SCALING BACK.—If the improper  
4 payment rate for outpatient therapy services de-  
5 termined for a 12-month period under subpara-  
6 graph (A) is 50 percent or less of the Medicare  
7 fee-for-service improper payment rate for such  
8 period, the Secretary shall—

9 “(i) reduce the amount and extent of  
10 medical review conducted for a prospective  
11 year under the process established in this  
12 subsection; and

13 “(ii) return an appropriate portion of  
14 the funding provided for such year under  
15 paragraph (11).”.

16 (2) GAO STUDY AND REPORT.—

17 (A) STUDY.—The Comptroller General of  
18 the United States shall conduct a study on the  
19 effectiveness of medical review of outpatient  
20 therapy services under section 1833(aa) of the  
21 Social Security Act, as added by paragraph (1).  
22 Such study shall include an analysis of—

23 (i) aggregate data on—

1 (I) the number of individuals,  
 2 therapy providers, and claims subject  
 3 to such review; and

4 (II) the number of reviews con-  
 5 ducted under such section; and

6 (ii) the outcomes of such reviews.

7 (B) REPORT.—Not later than 3 years after  
 8 the date of enactment of this Act, the Comp-  
 9 troller General shall submit to Congress a re-  
 10 port containing the results of the study under  
 11 subparagraph (A), together with recommenda-  
 12 tions for such legislation and administrative ac-  
 13 tion as the Comptroller General determines ap-  
 14 propriate.

15 (c) COLLECTION OF STANDARDIZED DATA ELE-  
 16 MENTS FOR OUTPATIENT THERAPY SERVICES.—

17 (1) COLLECTION OF STANDARDIZED DATA ELE-  
 18 MENTS FOR OUTPATIENT THERAPY SERVICES.—Sec-  
 19 tion 1834 of the Social Security Act (42 U.S.C.  
 20 1395m) is amended by adding at the end the fol-  
 21 lowing new subsection:

22 “(p) COLLECTION OF STANDARDIZED DATA ELE-  
 23 MENTS FOR OUTPATIENT THERAPY SERVICES.—

24 “(1) STANDARDIZED DATA ELEMENTS.—

1           “(A) IN GENERAL.—Not later than 6  
2 months after the date of enactment of this sub-  
3 section, the Secretary shall post on the Internet  
4 website of the Centers for Medicare & Medicaid  
5 Services a draft list of standardized data ele-  
6 ments for individuals receiving outpatient ther-  
7 apy services.

8           “(B) DOMAINS.—Such standardized data  
9 elements shall include information with respect  
10 to the following domains, as determined appro-  
11 priate by the Secretary:

12                   “(i) Demographic information.

13                   “(ii) Diagnosis.

14                   “(iii) Severity.

15                   “(iv) Affected body structures and  
16 functions.

17                   “(v) Limitations with activities of  
18 daily living and participation.

19                   “(vi) Functional status.

20                   “(vii) Other domains determined to be  
21 appropriate by the Secretary.

22           “(C) SOLICITATION OF INPUT.—The Sec-  
23 retary shall accept comments from stakeholders  
24 through the date that is 60 days after the date  
25 the Secretary posts the draft list of standard-



1            ized data elements pursuant to subparagraph  
2            (A). In seeking such comments, the Secretary  
3            shall use one or more mechanisms to solicit  
4            input from stakeholders that may include use of  
5            open door forums, town hall meetings, requests  
6            for information, or other mechanisms deter-  
7            mined appropriate by the Secretary.

8            “(D) OPERATIONAL LIST OF STANDARD-  
9            IZED DATA ELEMENTS.—Not later than 120  
10           days after the end of the comment period de-  
11           scribed in subparagraph (C), the Secretary, tak-  
12           ing into account such comments, shall post on  
13           the Internet website of the Centers for Medi-  
14           care & Medicaid Services an operational list of  
15           standardized data elements.

16           “(E) SUBSEQUENT REVISIONS.—Subse-  
17           quent revisions to the operational list of stand-  
18           ardized data elements shall be made through  
19           rulemaking. Such revisions may be based on ex-  
20           perience and input from stakeholders.

21           “(2) SYSTEM TO REPORT STANDARDIZED DATA  
22           ELEMENTS.—

23           “(A) IN GENERAL.—Not later than 18  
24           months after the date the Secretary posts the  
25           operational list of standardized data elements

1           pursuant to paragraph (1)(D), the Secretary  
2           shall develop and implement an electronic sys-  
3           tem (which may be a web portal) for therapy  
4           providers to report the standardized data ele-  
5           ments for individuals with respect to outpatient  
6           therapy services.

7           “(B) CONSULTATION.—The Secretary  
8           shall seek comments from stakeholders regard-  
9           ing the best way to report the standardized  
10          data elements.

11          “(3) REPORTING.—

12           “(A) FREQUENCY OF REPORTING.—The  
13           Secretary shall specify the frequency of report-  
14           ing standardized data elements. The Secretary  
15           shall seek comments from stakeholders regard-  
16           ing the frequency of the reporting of such data  
17           elements.

18           “(B) REPORTING REQUIREMENT.—Begin-  
19           ning on the date the system to report standard-  
20           ized data elements under this subsection is  
21           operational, no payment shall be made under  
22           this part for outpatient therapy services fur-  
23           nished to an individual unless a therapy pro-  
24           vider reports the standardized data elements for  
25           such individual.

1           “(4) REPORT ON NEW PAYMENT SYSTEM FOR  
2       OUTPATIENT THERAPY SERVICES.—

3           “(A) IN GENERAL.—Not later than 24  
4       months after the date described in paragraph  
5       (3)(B), the Secretary shall submit to Congress  
6       a report on the design of a new payment system  
7       for outpatient therapy services. The report shall  
8       include an analysis of the standardized data ele-  
9       ments collected and other appropriate data and  
10      information.

11          “(B) FEATURES.—Such report shall con-  
12      sider—

13           “(i) appropriate adjustments to pay-  
14      ment (such as case mix and outliers);

15           “(ii) payments on an episode of care  
16      basis; and

17           “(iii) reduced payment for multiple  
18      episodes.

19          “(C) CONSULTATION.—The Secretary shall  
20      consult with stakeholders regarding the design  
21      of such a new payment system.

22          “(5) IMPLEMENTATION.—

23           “(A) FUNDING.—For purposes of imple-  
24      menting this subsection, the Secretary shall  
25      provide for the transfer, from the Federal Sup-

1       plementary Medical Insurance Trust Fund  
2       under section 1841, of \$7,000,000 to the Cen-  
3       ters for Medicare & Medicaid Services Program  
4       Management Account for each of fiscal years  
5       2014 through 2018. Amounts transferred under  
6       this subparagraph shall remain available until  
7       expended.

8               “(B) ADMINISTRATION.—Chapter 35 of  
9       title 44, United States Code, shall not apply to  
10      specification of the standardized data elements  
11      and implementation of the system to report  
12      such standardized data elements under this  
13      subsection.

14              “(C) LIMITATION.—There shall be no ad-  
15      ministrative or judicial review under section  
16      1869, section 1878, or otherwise of the speci-  
17      fication of standardized data elements required  
18      under this subsection or the system to report  
19      such standardized data elements.

20              “(D) DEFINITION OF OUTPATIENT THER-  
21      APY SERVICES AND THERAPY PROVIDER.—In  
22      this subsection, the terms ‘outpatient therapy  
23      services’ and ‘therapy provider’ have the mean-  
24      ing given those term in section 1833(aa).”.

1           (2) SUNSET OF CURRENT CLAIMS-BASED COL-  
 2           LECTION OF THERAPY DATA.—Section 3005(g)(1) of  
 3           the Middle Class Tax Extension and Job Creation  
 4           Act of 2012 (42 U.S.C. 1395l note) is amended, in  
 5           the first sentence, by inserting “and ending on the  
 6           date the system to report standardized data ele-  
 7           ments under section 1834(p) of the Social Security  
 8           Act (42 U.S.C. 1395m(p)) is implemented,” after  
 9           “January 1, 2013,”.

10          (d) REPORTING OF CERTAIN INFORMATION.—Sec-  
 11       tion 1842(t) of the Social Security Act (42 U.S.C.  
 12       1395u(t)) is amended by adding at the end the following  
 13       new paragraph:

14           “(3) Each request for payment, or bill submitted, by  
 15       a therapy provider (as defined in section 1833(aa)(10))  
 16       for an outpatient therapy service (as defined in such sec-  
 17       tion) furnished by a therapy assistant on or after January  
 18       1, 2015, shall include (in a form and manner specified  
 19       by the Secretary) an indication that the service was fur-  
 20       nished by a therapy assistant.”.

21       **SEC. 203. MEDICARE AMBULANCE SERVICES.**

22           (a) EXTENSION OF CERTAIN AMBULANCE ADD-ON  
 23       PAYMENTS.—

24           (1)           GROUND           AMBULANCE.—Section  
 25       1834(l)(13)(A) of the Social Security Act (42 U.S.C.

1       1395m(l)(13)(A)) is amended by striking “April 1,  
2       2014” and inserting “January 1, 2019” each place  
3       it appears.

4           (2)   SUPER    RURAL    AMBULANCE.—Section  
5       1834(l)(12)(A) of the Social Security Act (42 U.S.C.  
6       1395m(l)(12)(A)) is amended, in the first sentence,  
7       by striking “April 1, 2014” and inserting “January  
8       1, 2019”.

9       (b) REQUIRING AMBULANCE PROVIDERS TO SUBMIT  
10   COST AND OTHER INFORMATION.—Section 1834(l) of the  
11   Social Security Act (42 U.S.C. 1395m(l)) is amended by  
12   adding at the end the following new paragraph:

13           “(16) SUBMISSION OF COST AND OTHER INFOR-  
14   MATION.—

15           “(A) DEVELOPMENT OF DATA COLLECTION  
16   SYSTEM.—The Secretary shall develop a data  
17   collection system (which may include use of a  
18   cost survey and standardized definitions) for  
19   providers and suppliers of ambulance services to  
20   collect cost, revenue, utilization, and other in-  
21   formation determined appropriate by the Sec-  
22   retary. Such system shall be designed to submit  
23   information—

1 “(i) needed to evaluate the appro-  
2 priateness of payment rates under this  
3 subsection;

4 “(ii) on the utilization of capital  
5 equipment and ambulance capacity; and

6 “(iii) on different types of ambulance  
7 services furnished in different geographic  
8 locations, including rural areas and low  
9 population density areas described in para-  
10 graph (12).

11 “(B) SPECIFICATION OF DATA COLLEC-  
12 TION SYSTEM.—

13 “(i) IN GENERAL.—Not later than  
14 July 1, 2015, the Secretary shall—

15 “(I) specify the data collection  
16 system under subparagraph (A) and  
17 the time period during which such  
18 data is required to be submitted; and

19 “(II) identify the providers and  
20 suppliers of ambulance services who  
21 would be required to submit the infor-  
22 mation under such data collection sys-  
23 tem.

24 “(ii) RESPONDENTS.—Subject to sub-  
25 paragraph (D)(ii), the Secretary shall de-

1           termine an appropriate sample of providers  
2           and suppliers of ambulance services to sub-  
3           mit information under the data collection  
4           system for each period for which reporting  
5           of data is required.

6           “(C) PENALTY FOR FAILURE TO REPORT  
7           COST AND OTHER INFORMATION.—Beginning  
8           on July 1, 2016, a 5 percent reduction to pay-  
9           ments under this part shall be made for a 1-  
10          year prospective period specified by the Sec-  
11          retary to a provider or supplier of ambulance  
12          services who—

13               “(i) is identified under subparagraph  
14               (B)(i)(II) as being required to submit the  
15               information under the data collection sys-  
16               tem; and

17               “(ii) does not submit such information  
18               during the period specified under subpara-  
19               graph (B)(i)(I).

20          “(D) ONGOING DATA COLLECTION.—

21               “(i) REVISION OF DATA COLLECTION  
22               SYSTEM.—The Secretary may, as deter-  
23               mined appropriate, periodically revise the  
24               data collection system.



1                   “(ii) SUBSEQUENT DATA COLLEC-  
2                   TION.—In order to continue to evaluate  
3                   the appropriateness of payment rates  
4                   under this subsection, the Secretary shall,  
5                   for years after 2016 (but not less often  
6                   than once every 3 years), require providers  
7                   and suppliers of ambulance services to sub-  
8                   mit information for a period the Secretary  
9                   determines appropriate. The penalty de-  
10                  scribed in subparagraph (C) shall apply to  
11                  such subsequent data collection periods.

12                 “(E) CONSULTATION.—The Secretary shall  
13                 consult with stakeholders in carrying out the  
14                 development of the system and collection of in-  
15                 formation under this paragraph, including the  
16                 activities described in subparagraphs (A) and  
17                 (D). Such consultation shall include the use of  
18                 requests for information and other mechanisms  
19                 determined appropriate by the Secretary.

20                 “(F) ADMINISTRATION.—Chapter 35 of  
21                 title 44, United States Code, shall not apply to  
22                 the collection of information required under this  
23                 subsection.

24                 “(G) LIMITATIONS ON REVIEW.—There  
25                 shall be no administrative or judicial review

under section 1869, section 1878, or otherwise of the data collection system or identification of respondents under this paragraph.

“(H) FUNDING FOR IMPLEMENTATION.—

For purposes of carrying out subparagraph (A), the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of \$1,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2014. Amounts transferred under this subparagraph shall remain available until expended.”.

**SEC. 204. REVISION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.**

(a) PERMANENT EXTENSION OF PAYMENT METHODOLOGY.—

(1) IN GENERAL.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(A) in clause (i), by striking “and before April 1, 2014,”; and

(B) in clause (ii)(II), by striking “and before April 1, 2014,”.

(2) CONFORMING AMENDMENTS.—

1 (A) TARGET AMOUNT.—Section  
2 1886(b)(3)(D) of the Social Security Act (42  
3 U.S.C. 1395ww(b)(3)(D)) is amended—

4 (i) in the matter preceding clause (i),  
5 by striking “and before April 1, 2014,”;  
6 and

7 (ii) in clause (iv), by striking  
8 “through fiscal year 2013 and the portion  
9 of fiscal year 2014 before April 1, 2014”  
10 and inserting “or a subsequent fiscal  
11 year”.

12 (B) HOSPITAL VALUE-BASED PURCHASING  
13 PROGRAM.—Section 1886(o)(7)(D)(ii)(I) of the  
14 Social Security Act (42 U.S.C.  
15 1395ww(o)(7)(D)(ii)(I)) is amended by striking  
16 “(with respect to discharges occurring during  
17 fiscal year 2012 and 2013)”.

18 (C) HOSPITAL READMISSION REDUCTION  
19 PROGRAM.—Section 1886(q)(2)(B)(i) of the So-  
20 cial Security Act (42 U.S.C.  
21 1395ww(q)(2)(B)(i)) is amended by striking  
22 “(with respect to discharges occurring during  
23 fiscal years 2012 and 2013)”.

24 (D) PERMITTING HOSPITALS TO DECLINE  
25 RECLASSIFICATION.—Section 13501(e)(2) of

1 the Omnibus Budget Reconciliation Act of 1993  
2 (42 U.S.C. 1395ww note) is amended by strik-  
3 ing “fiscal year 1998, fiscal year 1999, or fiscal  
4 year 2000 through the first 2 quarters of fiscal  
5 year 2014” and inserting “or fiscal year 1998  
6 or a subsequent fiscal year”.

7 (b) GAO STUDY AND REPORT ON MEDICARE-DE-  
8 PENDENT HOSPITALS.—

9 (1) STUDY.—The Comptroller General of the  
10 United States shall conduct a study on the following:

11 (A) The payor mix of medicare-dependent,  
12 small rural hospitals (as defined in section  
13 1886(d)(5)(G)(iv)), how such mix will trend in  
14 future years, and whether or not the require-  
15 ment under subclause (IV) of such section  
16 should be revised.

17 (B) The characteristics of medicare-de-  
18 pendent, small rural hospitals that meet the re-  
19 quirement of such subclause (IV) through the  
20 application of paragraph (a)(iii)(A) or  
21 (a)(iii)(B) of section 412.108 of the Code of  
22 Federal Regulations, including Medicare inpa-  
23 tient and outpatient utilization, payor mix, and  
24 financial status, including Medicare and total

1 margins, and whether or not Medicare pay-  
2 ments for such hospitals should be revised.

3 (C) Such other items related to medicare-  
4 dependent, small rural hospitals as the Comp-  
5 troller General determines appropriate.

6 (2) REPORT.—Not later than 12 months after  
7 the date of the enactment of this Act, the Comp-  
8 troller General of the United States shall submit to  
9 Congress a report on the study conducted under  
10 paragraph (1), together with recommendations for  
11 such legislation and administrative action as the  
12 Comptroller General determines appropriate.

13 (c) IMPLEMENTATION.—Notwithstanding any other  
14 provision of law, for purposes of fiscal year 2014, the Sec-  
15 retary of Health and Human Services may implement the  
16 provisions of, and the amendments made by, this section  
17 through program instruction or otherwise.

18 **SEC. 205. REVISION OF MEDICARE INPATIENT HOSPITAL**  
19 **PAYMENT ADJUSTMENT FOR LOW-VOLUME**  
20 **HOSPITALS.**

21 (a) IN GENERAL.—Section 1886(d)(12) of the Social  
22 Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

23 (1) in subparagraph (B)—

1 (A) in the subparagraph heading, by in-  
2 serting “FOR FISCAL YEARS 2005 THROUGH  
3 2010” after “INCREASE”; and

4 (B) in the matter preceding clause (i), by  
5 striking “and for discharges occurring in the  
6 portion of fiscal year 2014 beginning on April  
7 1, 2014, fiscal year 2015, and subsequent  
8 years”;

9 (2) in subparagraph (C)(i)—

10 (A) by striking “fiscal years 2011, 2012,  
11 and 2013, and the portion of fiscal year 2014  
12 before” and inserting “fiscal year 2011 and  
13 subsequent fiscal years,” each place it appears;  
14 and

15 (B) by striking “or portion of fiscal year”  
16 after “during the fiscal year”; and

17 (3) in subparagraph (D)—

18 (A) in the heading, by striking “TEM-  
19 PORARY APPLICABLE PERCENTAGE INCREASE”  
20 and inserting “APPLICABLE PERCENTAGE IN-  
21 CREASE FOR FISCAL YEAR 2011 AND SUBSE-  
22 QUENT FISCAL YEARS”;

23 (B) by striking “fiscal years 2011, 2012,  
24 and 2013, and the portion of fiscal year 2014

1 before April 1, 2014” and inserting “fiscal year  
2 2011 or a subsequent fiscal year”; and

3 (C) by striking “or the portion of fiscal  
4 year” after “in the fiscal year”.

5 (b) IMPLEMENTATION.—Notwithstanding any other  
6 provision of law, for purposes of fiscal year 2014, the Sec-  
7 retary of Health and Human Services may implement the  
8 provisions of, and the amendments made by, this section  
9 through program instruction or otherwise.

10 **SEC. 206. SPECIALIZED MEDICARE ADVANTAGE PLANS FOR**  
11 **SPECIAL NEEDS INDIVIDUALS.**

12 (a) EXTENSION.—Section 1859(f)(1) of the Social  
13 Security Act (42 U.S.C. 1395w–28(f)(1)) is amended—

14 (1) by striking “ENROLLMENT.—In the case”  
15 and inserting “ENROLLMENT.—

16 “(A) IN GENERAL.—Subject to subpara-  
17 graphs (B) and (C), in the case”;

18 (2) in subparagraph (A), as added by para-  
19 graph (1), by striking “and for periods before Janu-  
20 ary 1, 2016”; and

21 (3) by adding at the end the following new sub-  
22 paragraphs:

23 “(B) APPLICATION TO DUAL SNPS.—Sub-  
24 paragraph (A) shall only apply to a specialized  
25 MA plan for special needs individuals described

in subsection (b)(6)(B)(ii) for periods before January 1, 2021.

“(C) APPLICATION TO SEVERE OR DISABLING CHRONIC CONDITION SNPS.—Subparagraph (A) shall only apply to a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii) for periods before January 1, 2018.”.

(b) INCREASED INTEGRATION OF DUAL SNPS.—

(1) IN GENERAL.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)) is amended—

(A) in paragraph (3), by adding at the end the following new subparagraph:

“(F) The plan meets the requirements applicable under paragraph (8).”; and

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

“(8) INCREASED INTEGRATION OF DUAL SNPS.—

“(A) DESIGNATED CONTACT.—The Secretary, acting through the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) established under section 2602 of the Patient Protection and Affordable Care Act (in this paragraph referred to as the ‘MMCO’),



1 shall serve as a dedicated point of contact for  
2 States to address misalignments that arise with  
3 the integration of specialized MA plans for spe-  
4 cial needs individuals described in subsection  
5 (b)(6)(B)(ii) under this paragraph. Consistent  
6 with such role, the MMCO shall—

7 “(i) establish a uniform process for  
8 disseminating to State Medicaid agencies  
9 information under this title impacting con-  
10 tracts between such agencies and such  
11 plans under this subsection; and

12 “(ii) establish basic resources for  
13 States interested in exploring such plans  
14 as a platform for integration.

15 “(B) UNIFIED GRIEVANCES AND APPEALS  
16 PROCESS.—

17 “(i) IN GENERAL.—Not later than  
18 April 1, 2015, the Secretary shall establish  
19 procedures unifying the grievances and ap-  
20 peals procedures under sections 1852(f),  
21 1852(g), 1902(a)(3), and 1902(a)(5) for  
22 items and services provided by specialized  
23 MA plans for special needs individuals de-  
24 scribed in subsection (b)(6)(B)(ii) under  
25 this title and title XIX. The Secretary

1 shall solicit comment in developing such  
2 procedures from States, plans, beneficiaries  
3 and their representatives, and other rel-  
4 evant stakeholders.

5 “(ii) PROCEDURES.—The procedures  
6 established under clause (i) shall—

7 “(I) adopt the provisions for the  
8 enrollee under current law that are  
9 most protective for the enrollee and  
10 are compatible with unified time-  
11 frames and consolidated access to ex-  
12 ternal review under an integrated  
13 process;

14 “(II) take into account dif-  
15 ferences in State plans under title  
16 XIX;

17 “(III) be easily navigable by an  
18 enrollee; and

19 “(IV) include the elements de-  
20 scribed in clause (iii), as applicable, to  
21 both unified appeals and unified griev-  
22 ance procedures.

23 “(iii) ELEMENTS DESCRIBED.—The  
24 following elements are described in this  
25 clause:

1 “(I) Single notification of all ap-  
2 plicable grievances and appeal rights  
3 under this title and title XIX.

4 “(II) Single pathways for resolu-  
5 tion of any grievance or appeal related  
6 to a particular item or service pro-  
7 vided by specialized MA plans for spe-  
8 cial needs individuals described in  
9 subsection (b)(6)(B)(ii) under this  
10 title and title XIX.

11 “(III) Notices written in plain  
12 language and available in a language  
13 and format that is accessible to the  
14 enrollee.

15 “(IV) Unified timeframes for  
16 grievances and appeals processes,  
17 such as an individual’s filing of a  
18 grievance or appeal, a plan’s acknowl-  
19 edgment and resolution of a grievance  
20 or appeal, and notification of decisions  
21 with respect to a grievance or appeal.

22 “(V) Guidelines for how the plan  
23 must process, track, and resolve griev-  
24 ances and appeals, to ensure bene-  
25 ficiaries are notified on a timely basis

1 of decisions that are made throughout  
 2 the grievance or appeals process and  
 3 are able to easily determine the status  
 4 of a grievance or appeal.

5 “(iv) INCORPORATION OF BENE-  
 6 FICIARY PROTECTIONS AND IMPLE-  
 7 MENTING REGULATIONS.—The unified pro-  
 8 cedures under clause (i) shall incorporate  
 9 beneficiary protections under current law  
 10 and implementing regulations that provide  
 11 continuation of benefits pending appeal  
 12 under title XIX.

13 “(C) REQUIREMENT FOR UNIFIED GRIEV-  
 14 ANCES AND APPEALS.—

15 “(i) IN GENERAL.—For 2017 and  
 16 subsequent years, the contract of a special-  
 17 ized MA plan for special needs individuals  
 18 described in subsection (b)(6)(B)(ii) with a  
 19 State Medicaid agency under this sub-  
 20 section shall require the use of unified  
 21 grievances and appeals procedures as de-  
 22 scribed in subparagraph (B).

23 “(ii) CONSIDERATION OF APPLICA-  
 24 TION FOR OTHER SNPS.—The Secretary  
 25 shall consider applying the unified griev-

ances and appeals process described in subparagraph (B) to specialized MA plans for special needs individuals described in subsection (b)(6)(B)(i) and subsection (b)(6)(B)(iii) that have a substantial portion of enrollees who are dually eligible for benefits under this title and title XIX and are at risk for full benefits under title XIX.

“(D) REQUIREMENT FOR FULL INTEGRATION FOR CERTAIN DUAL SNPS.—

“(i) REQUIREMENT.—Subject to the succeeding provisions of this subparagraph, for 2018 and subsequent years, a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) shall—

“(I) integrate all benefits under this title and title XIX; and

“(II) meet the requirements of a fully integrated plan described in section 1853(a)(1)(B)(iv)(II) (other than the requirement that the plan have similar average levels of frailty, as determined by the Secretary, as the

1 PACE program), including with re-  
2 spect to long-term care services or be-  
3 havioral health services to the extent  
4 State law permits capitation of those  
5 services under such plan.

6 “(ii) INITIAL SANCTIONS FOR FAIL-  
7 URE TO MEET REQUIREMENT FOR 2018 OR  
8 2019.—For each of 2018 and 2019, if the  
9 Secretary determines that a plan has failed  
10 to meet the requirement described in  
11 clause (i), the Secretary shall impose one  
12 of the following on the plan:

13 “(I) A reduction in payment to  
14 the plan under this part in an amount  
15 at least equal to the portion of the  
16 monthly rebate computed under sec-  
17 tion 1854(b)(1)(C)(i) for the plan and  
18 year.

19 “(II) Closing enrollment in the  
20 plan.

21 “(III) Sanctioning the plan in ac-  
22 cordance with section 1857(g).

23 “(IV) Other reasonable action  
24 (other than the sanction described in

1 clause (iii)) the Secretary determines  
 2 appropriate.

3 “(iii) SANCTIONS FOR FAILURE TO  
 4 MEET REQUIREMENT FOR 2020 AND SUBSE-  
 5 QUENT YEARS.—For 2020 and subsequent  
 6 years, if the Secretary determines that a  
 7 plan has failed to meet the requirement de-  
 8 scribed in clause (i), the plan shall be  
 9 deemed to no longer meet the definition of  
 10 a specialized MA plan for special needs in-  
 11 dividuals described in subsection  
 12 (b)(6)(B)(ii).”.

13 (2) CONFORMING AMENDMENT TO RESPON-  
 14 SIBILITIES OF FEDERAL COORDINATED HEALTH  
 15 CARE OFFICE (MMCO).—Section 2602(d) of the Pa-  
 16 tient Protection and Affordable Care Act (42 U.S.C.  
 17 1315b(d)) is amended by adding at the end the fol-  
 18 lowing new paragraphs:

19 “(6) To act as a designated contact for States  
 20 under subsection (f)(8)(A) of section 1859 of the So-  
 21 cial Security Act (42 U.S.C. 1395w–28) with respect  
 22 to the integration of specialized MA plans for special  
 23 needs individuals described in subsection  
 24 (b)(6)(B)(ii) of such section.

1           “(7) To be responsible for developing regula-  
 2           tions and guidance related to the implementation of  
 3           a unified grievance and appeals process as described  
 4           in subparagraphs (B) and (C) of section 1859(f)(8)  
 5           of the Social Security Act (42 U.S.C. 1395w-  
 6           28(f)(8)).”.

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 15 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 17 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-star rating or  
25 the highest rating possible overall or for an

1 individual measure in order to ensure that  
2 the plan is not punished in cases where it  
3 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 may include Medicare Health Outcomes Survey (HOS), Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and quality measures under part D; 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.

1                   “(B) CONSIDERATION OF CHANGE.—After  
 2                   making a determination under subparagraph  
 3                   (A), the Secretary shall consider requiring such  
 4                   reporting and applying such quality measures  
 5                   at the plan level as described in such subpara-  
 6                   graph.”.

7 **SEC. 207. REASONABLE COST REIMBURSEMENT CON-**  
 8 **TRACTS.**

9                   (a) ONE-YEAR TRANSITION AND NOTICE REGARDING  
 10 TRANSITION.—Section 1876(h)(5)(C) of the Social Secu-  
 11 rity Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

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

15                   (2) by adding at the end the following new  
 16                   clauses:

17                   “(iv) In the case of an eligible organization that is  
 18                   offering a reasonable cost reimbursement contract that  
 19                   may no longer be extended or renewed because of the ap-  
 20                   plication of clause (ii), the following shall apply:

21                   “(I) Notwithstanding such clause, such contract  
 22                   may be extended or renewed for the two years subse-  
 23                   quent to the previous year described in clause (ii).  
 24                   The second of the two years described in the pre-  
 25                   ceding sentence with respect to a contract is referred

1 to in this subsection as the ‘last reasonable cost re-  
2 imbursement contract year for the contract’.

3 “(II) The organization may not enroll any new  
4 enrollees under such contract during the last reason-  
5 able cost reimbursement contract year for the con-  
6 tract.

7 “(III) Not later than a date determined appro-  
8 priate by the Secretary prior to the beginning of the  
9 last reasonable cost reimbursement contract year for  
10 the contract, the organization shall provide notice to  
11 the Secretary as to whether or not the organization  
12 will apply to have the contract converted over and  
13 offered as a Medicare Advantage plan under part C  
14 for the year following the last reasonable cost reim-  
15 bursement contract year for the contract.

16 “(IV) If the organization provides the notice de-  
17 scribed in subclause (III) that the contract will be  
18 converted, the organization shall, not later than a  
19 date determined appropriate by the Secretary, pro-  
20 vide the Secretary with such information as the Sec-  
21 retary determines appropriate in order to carry out  
22 sections 1851(c)(4) and 1854(a)(5), including sub-  
23 paragraph (C) of such section.

24 “(v) If an eligible organization that is offering a rea-  
25 sonable cost reimbursement contract that is extended or



1 renewed pursuant to clause (iv) provides the notice de-  
 2 scribed in clause (iv)(III) that the contract will be con-  
 3 verted, the following provisions shall apply:

4 “(I) The deemed enrollment under section  
 5 1851(c)(4).

6 “(II) The special rule for quality increases  
 7 under 1853(o)(3)(A)(iv).”.

8 (b) DEEMED ENROLLMENT FROM REASONABLE  
 9 COST REIMBURSEMENT CONTRACTS CONVERTED TO  
 10 MEDICARE ADVANTAGE PLANS.—

11 (1) IN GENERAL.—Section 1851(c) of the So-  
 12 cial Security Act (42 U.S.C. 1395w–21(c)) is  
 13 amended—

14 (A) in paragraph (1), by striking “Such  
 15 elections” and inserting “Subject to paragraph  
 16 (4), such elections”; and

17 (B) by adding at the end the following:

18 “(4) DEEMED ENROLLMENT RELATING TO CON-  
 19 VERTED REASONABLE COST REIMBURSEMENT CON-  
 20 TRACTS.—

21 “(A) IN GENERAL.—On the first day of  
 22 the annual, coordinated election period under  
 23 subsection (e)(3) for plan years beginning on or  
 24 after January 1, 2017, an MA eligible indi-  
 25 vidual described in clause (i) or (ii) of subpara-

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)”;

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”;

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.”.

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking “March 2104” and inserting “December 2018”.

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).

(c) ELIMINATING ALLOCATIONS.—Section 1933 of the Social Security Act (42 U.S.C. 1396u–3) is amended by striking subsections (c) and (g).

14 (d) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 1933 of the Social Security Act (42 U.S.C. 1396u–3), as amended by subsections (b) and (c), is further amended—

(A) by striking subsection (a) and inserting the following new subsection:

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-



(4) in subsection (f), by striking “2010 through 2014” and inserting “2015 through 2019”.

16 SEC. 223. FAMILY-TO-FAMILY HEALTH INFORMATION CEN-  
17 TERS.

20 (1) in paragraph (1)(A), by striking clause (iv)  
21 and inserting the following:

24 (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 payment errors and most expen-  
21                   sive payment errors 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                 NPI or other provider identifier of the pro-  
15                 vider or supplier, the amount of the im-  
16                 proper payment, and any other information  
17                 the Secretary 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 Centers for Medicare & Medicaid Services  
 4 Program Management Account for purposes of car-  
 5 rying out this subsection and to implement correc-  
 6 tive actions to help reduce the error rate of pay-  
 7 ments under this title. The amount retained under  
 8 the preceding sentence shall not exceed an amount  
 9 equal to 25 percent of the amounts recovered under  
 10 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 1874A(h)(8)” after “paragraph (1)(C)”.

15 (3) EFFECTIVE DATE.—The amendments made  
 16 by this subsection take effect on the date of enact-  
 17 ment of this Act.

18 (b) TRANSPARENCY.—Section 1893(h)(8) of the So-  
 19 cial Security Act (42 U.S.C. 1395ddd(h)(8)) is amended—

20 (1) by striking “REPORT.—The Secretary” and  
 21 inserting “REPORT.—

22 “(A) IN GENERAL.—The Secretary”; and

23 (2) by adding at the end the following new sub-  
 24 paragraph:

1                   “(B) INCLUSION OF CERTAIN INFORMA-  
2                   TION.—

3                   “(i) IN GENERAL.—For reports sub-  
4                   mitted under this paragraph for 2015 or a  
5                   subsequent year, each such report shall in-  
6                   clude the information described in clause  
7                   (ii) with respect to each of the following  
8                   categories of audits carried out by recovery  
9                   audit contractors under this subsection:

10                               “(I) Automated.

11                               “(II) Complex.

12                               “(III) Medical necessity review.

13                               “(IV) Part A.

14                               “(V) Part B.

15                               “(VI) Durable medical equip-  
16                   ment.

17                   “(ii) INFORMATION DESCRIBED.—For  
18                   purposes of clause (i), the information de-  
19                   scribed in this clause, with respect to a  
20                   category of audit described in clause (i), is  
21                   the result of all appeals for each individual  
22                   level of appeals in such category.”.

23                   (c) RECOVERY AUDIT CONTRACTOR DEMONSTRA-  
24                   TION PROJECT.—

1           (1) IN GENERAL.—The Secretary shall conduct  
2       a demonstration project under title XVIII of the So-  
3       cial Security Act that—

4           (A) targets audits by recovery audit con-  
5       tractors under section 1893(h) of the Social Se-  
6       curity Act (42 U.S.C. 1395ddd(h)) with respect  
7       to high error providers of services and suppliers  
8       identified under paragraph (3); and

9           (B) rewards low error providers of services  
10      and suppliers identified under such paragraph.

11       (2) SCOPE.—

12           (A) DURATION.—The demonstration  
13      project shall be implemented not later than  
14      January 1, 2015, and shall be conducted for a  
15      period of three years.

16           (B) DEMONSTRATION AREA.—In deter-  
17      mining the geographic area of the demonstra-  
18      tion project, the Secretary shall consider the  
19      following:

20           (i) The total number of providers of  
21      services and suppliers in the region.

22           (ii) The diversity of types of providers  
23      of services and suppliers in the region.

24           (iii) The level and variation of im-  
25      proper payment rates of and among indi-

1           vidual providers of services and suppliers  
2           in the region.

3           (iv) The inclusion of a mix of both  
4           urban and rural areas.

5           (3) IDENTIFICATION OF LOW ERROR AND HIGH  
6           ERROR PROVIDERS OF SERVICES AND SUPPLIERS.—

7           (A) IN GENERAL.—Subject to paragraph  
8           (5), in conducting the demonstration project,  
9           the Secretary shall identify the following two  
10          groups of providers in accordance with this  
11          paragraph:

12           (i) Low error providers of services and  
13           suppliers.

14           (ii) High error providers of services  
15           and suppliers.

16           (B) ANALYSIS.—For purposes of identi-  
17          fying the groups under subparagraph (A), the  
18          Secretary shall analyze each of the following:

19           (i) The improper payment rates of in-  
20           dividual providers of services and suppliers.

21           (ii) The amount of improper payments  
22           made to individual providers of services  
23           and suppliers.

1 (iii) The frequency of errors made by  
2 the provider of services or supplier over  
3 time.

4 (iv) Other information determined ap-  
5 propriate by the Secretary.

6 (C) ASSIGNMENT BASED ON COMPOSITE  
7 SCORE.—The Secretary shall analyze the infor-  
8 mation under subparagraph (B) and assign se-  
9 lected providers of services and suppliers under  
10 the demonstration program as follows:

11 (i) Providers of services and suppliers  
12 with high, expensive, and frequent errors  
13 relative to national error rates for specific  
14 items and services shall be identified as  
15 high error providers of services and sup-  
16 pliers under subparagraph (A).

17 (ii) Providers of services and suppliers  
18 with few, inexpensive, and infrequent er-  
19 rors relative to national error rates for spe-  
20 cific items and services shall be identified  
21 as low error providers of services and sup-  
22 pliers under such subparagraph.

23 (iii) Only a small proportion of the  
24 total providers of services and suppliers  
25 and individual types of providers of serv-

1           ices and suppliers in the geographic area  
2           of the demonstration project shall be as-  
3           signed to either group identified under  
4           such subparagraph.

5           (D) TIMEFRAME OF IDENTIFICATION.—

6                 (i) IN GENERAL.—Any identification  
7           of a provider of services or a supplier  
8           under subparagraph (A) shall be for a pe-  
9           riod of 3 months.

10                (ii) REEVALUATION.—The Secretary  
11           shall reevaluate each such identification at  
12           the end of such period.

13                (iii) USE OF MOST CURRENT INFOR-  
14           MATION.—In carrying out the reevaluation  
15           under clause (ii) with respect to a provider  
16           of services or supplier, the Secretary  
17           shall—

18                       (I) consider the most current in-  
19           formation available with respect to the  
20           provider of services or supplier under  
21           the analysis under subparagraph (B);  
22           and

23                       (II) take into account improve-  
24           ment or regression of the provider of  
25           services or supplier.

1           (4) ADJUSTMENT OF RECORD REQUEST MAX-  
2           IMUM.—Subject to paragraph (5), under the dem-  
3           onstration project, the Secretary shall establish pro-  
4           cedures to—

5                   (A) increase the maximum record request  
6                   made by recovery audit contractors to providers  
7                   of services and suppliers identified as high error  
8                   providers of services and suppliers under para-  
9                   graph (3); and

10                   (B) decrease the maximum record request  
11                   made by recovery audit contractors to providers  
12                   of services and suppliers identified as low error  
13                   providers of services and supplier under such  
14                   paragraph.

15           (5) FLEXIBILITY.—Notwithstanding para-  
16           graphs (3) and (4), the Secretary may identify more  
17           than two groups of providers in a geographical area.  
18           If the Secretary identifies more than two groups of  
19           providers in a geographic area pursuant to the pre-  
20           ceding sentence—

21                   (A) providers shall be assigned to such  
22                   groups in a manner similar to the manner in  
23                   which providers are assigned to a group under  
24                   paragraph (3); and

1 (B) the maximum record request would be  
2 adjusted in a manner similar to the manner in  
3 which the maximum record request is adjusted  
4 under paragraph (4).

5 (6) ADDITIONAL ADJUSTMENTS.—

6 (A) IN GENERAL.—Under the demonstra-  
7 tion project, the Secretary may make additional  
8 adjustments to requirements for recovery audit  
9 contractors under section 1893(h) of the Social  
10 Security Act (42 U.S.C. 1395ddd(h)) and the  
11 conduct of audits with respect to low error pro-  
12 viders of services and suppliers identified under  
13 paragraph (3) (or paragraph (5), as the case  
14 may be) and high error providers of services  
15 and suppliers identified under paragraph (3)  
16 (or paragraph (5), as the case may be) as the  
17 Secretary determines necessary in order to  
18 incentivize reductions in improper payment  
19 rates under title XVIII of such Act (42 U.S.C.  
20 1395 et seq.).

21 (B) LIMITATION.—The Secretary shall not  
22 exempt any group of providers of services or  
23 suppliers in the demonstration project, absent  
24 evidence of fraud or abuse, from being subject



1 to audit by a recovery audit contractor under  
2 such section 1893(h).

3 (7) EVALUATION AND REPORT.—

4 (A) EVALUATION.—The Inspector General  
5 of the Department of Health and Human Serv-  
6 ices shall conduct an evaluation of the dem-  
7 onstration project under this subsection. The  
8 evaluation shall include an analysis of—

9 (i) the error rates of providers of serv-  
10 ices and suppliers—

11 (I) identified under paragraph  
12 (3) (or paragraph (5), as the case  
13 may be) as low error providers of  
14 services and suppliers;

15 (II) identified under paragraph  
16 (3) (or paragraph (5), as the case  
17 may be) as high error providers of  
18 services and suppliers; and

19 (III) that are located in the geo-  
20 graphic area of the demonstration  
21 project and are not identified as either  
22 a low error or high error provider of  
23 services or supplier under such para-  
24 graphs; 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                   paragraphs.

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                  (8) FUNDING.—

15                  (A) FUNDING FOR IMPLEMENTATION.—  
 16                  After application of paragraph (1)(C) of section  
 17                  1893(h) of the Social Security Act (42 U.S.C.  
 18                  1395ddd(h)) and section 1874A(h)(8) of such  
 19                  Act (42 U.S.C. 1395kk–1(h)(8)), as added by  
 20                  subsection (a)(1), the Secretary shall retain  
 21                  \$10,000,000 of the amounts recovered by recov-  
 22                  ery audit contractors under such section  
 23                  1893(h), which shall be available to the Centers  
 24                  for Medicare & Medicaid Services Program  
 25                  Management Account for purposes of carrying

1 out the demonstration project under this sub-  
2 section (other than the evaluation and report  
3 under paragraph (7)). The amount retained  
4 under the preceding sentence shall remain avail-  
5 able until expended.

6 (B) FUNDING FOR INSPECTOR GENERAL  
7 EVALUATION AND REPORT.—After application  
8 of such paragraph (1)(C), such section  
9 1874A(h)(8), as so added, and subparagraph  
10 (A), the Secretary shall retain \$245,000 of the  
11 amounts recovered by recovery audit contrac-  
12 tors under such section 1893(h), which shall be  
13 transferred to the Inspector General of the De-  
14 partment of Health and Human Services for  
15 purposes of carrying out the evaluation and re-  
16 port under paragraph (7). The amount trans-  
17 ferred under the preceding sentence shall re-  
18 main available until expended.

19 (C) NO REDUCTION IN PAYMENTS TO RE-  
20 COVERY AUDIT CONTRACTORS.—Nothing in  
21 subparagraph (A) or (B) of this paragraph or  
22 such section 1874A(h)(8), as so added, shall re-  
23 duce amounts available for payments to recov-  
24 ery audit contractors under such section  
25 1893(h).

1 (D) FUNDING CONFORMING AMEND-  
2 MENT.—Section 1893(h)(2) of the Social Secu-  
3 rity Act (42 U.S.C. 1395ddd(h)(2)), as amend-  
4 ed by subsection (a)(2), is amended by striking  
5 “or section 1874A(h)(8)” and inserting “, sec-  
6 tion 1874A(h)(8), or subparagraphs (A) and  
7 (B) of section 301(c)(8) of the Commonsense  
8 Medicare SGR Repeal and Beneficiary Access  
9 Improvement Act of 2014”.

10 (9) DEFINITIONS.—In this section:

11 (A) DEMONSTRATION PROJECT.—The term  
12 “demonstration project” means the demonstra-  
13 tion project under this subsection.

14 (B) PROVIDER OF SERVICES.—The term  
15 “provider of services” has the meaning given  
16 that term in section 1861(u).

17 (C) RECOVERY AUDIT CONTRACTOR.—The  
18 term “recovery audit contractor” means an en-  
19 tity with a contract under section 1893(h) of  
20 the Social Security Act (42 U.S.C.  
21 1395ddd(h)).

22 (D) SECRETARY.—The term “Secretary”  
23 means the Secretary of Health and Human  
24 Services.

1 (E) SUPPLIER.—The term “supplier” has  
2 the meaning given that term in section 1861(d).

3 **SEC. 302. AUTHORITY FOR MEDICAID FRAUD CONTROL**  
4 **UNITS TO INVESTIGATE AND PROSECUTE**  
5 **COMPLAINTS OF ABUSE AND NEGLECT OF**  
6 **MEDICAID PATIENTS IN HOME AND COMMU-**  
7 **NITY-BASED SETTINGS.**

8 (a) IN GENERAL.—Section 1903(q)(4)(A) of the So-  
9 cial Security Act (42 U.S.C. 1396b(q)(4)(A)) is amended  
10 to read as follows:

11 “(4)(A) The entity’s function includes a state-  
12 wide program for the—

13 “(i) investigation and prosecution, or refer-  
14 ral for prosecution or other action, of com-  
15 plaints of abuse or neglect of patients in health  
16 care facilities which receive payments under the  
17 State plan under this title or under a waiver of  
18 such plan;

19 “(ii) at the option of the entity, investiga-  
20 tion and prosecution, or referral for prosecution  
21 or other action, of complaints of abuse or ne-  
22 glect of individuals in connection with any as-  
23 pect of the provision of medical assistance and  
24 the activities of providers of such assistance in  
25 a home or community based setting that is paid

1 for under the State plan under this title or  
 2 under a waiver of such plan; and

3 “(iii) at the option of the entity, investiga-  
 4 tion and prosecution, or referral for prosecution  
 5 or other action, of complaints of abuse or ne-  
 6 glect of patients residing in board and care fa-  
 7 cilities.”.

8 (b) EFFECTIVE DATE.—The amendment made by  
 9 subsection (a) shall take effect on January 1, 2015.

10 **SEC. 303. IMPROVED USE OF FUNDS RECEIVED BY THE HHS**  
 11 **INSPECTOR GENERAL FROM OVERSIGHT AND**  
 12 **INVESTIGATIVE ACTIVITIES.**

13 (a) IN GENERAL.—Section 1128C(b) of the Social  
 14 Security Act (42 U.S.C. 1320a–7c(b)) is amended to read  
 15 as follows:

16 “(b) ADDITIONAL USE OF FUNDS BY INSPECTOR  
 17 GENERAL.—

18 “(1) COLLECTIONS FROM MEDICARE AND MED-  
 19 ICAID RECOVERY ACTIONS.—Notwithstanding section  
 20 3302 of title 31, United States Code, or any other  
 21 provision of law affecting the crediting of collections,  
 22 the Inspector General of the Department of Health  
 23 and Human Services may receive and retain for cur-  
 24 rent use three percent of all amounts collected pur-  
 25 suant to civil debt collection and administrative en-

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to funds received from settlements finalized, judgments entered, or final agency decisions issued, on or after the date of the enactment of this Act.

(a) REQUIRING VALID PRESCRIBER NATIONAL PRO-  
VIDER IDENTIFIERS ON PHARMACY CLAIMS.—Section  
1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–  
104(c)) is amended by adding at the end the following new  
paragraph:

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1           “(A) IN GENERAL.—For plan year 2015  
 2           and subsequent plan years, subject to subpara-  
 3           graph (B), the Secretary shall prohibit PDP  
 4           sponsors of prescription drug plans from paying  
 5           claims for prescription drugs under this part  
 6           that do not include a valid prescriber National  
 7           Provider Identifier.

8           “(B) PROCEDURES.—The Secretary shall  
 9           establish procedures for determining the validity  
 10          of prescriber National Provider Identifiers  
 11          under subparagraph (A).

12          “(C) REPORT.—Not later than January 1,  
 13          2017, the Inspector General of the Department  
 14          of Health and Human Services shall submit to  
 15          Congress a report on the effectiveness of the  
 16          procedures established under subparagraph  
 17          (B).”.

18          (b) REFORMING HOW CMS TRACKS AND CORRECTS  
 19          THE VULNERABILITIES IDENTIFIED BY RECOVERY AUDIT  
 20          CONTRACTORS.—Section 1893(h) of the Social Security  
 21          Act (42 U.S.C. 1395ddd(h)) is amended—

22               (1) in paragraph (8), as amended by section  
 23               301(b), by adding at the end the following new sub-  
 24               paragraphs:



1           “(C) INCLUSION OF IMPROPER PAYMENT  
2 VULNERABILITIES IDENTIFIED.—For reports  
3 submitted under this paragraph for 2015 or a  
4 subsequent year, each such report shall in-  
5 clude—

6           “(i) a description of—

7                   “(I) the types and financial cost  
8 to the program under this title of im-  
9 proper payment vulnerabilities identi-  
10 fied by recovery audit contractors  
11 under this subsection; and

12                   “(II) how the Secretary is ad-  
13 dressing such improper payment  
14 vulnerabilities; and

15           “(ii) an assessment of the effective-  
16 ness of changes made to payment policies  
17 and procedures under this title in order to  
18 address the vulnerabilities so identified.

19           “(D) LIMITATION.—The Secretary shall  
20 ensure that each report submitted under sub-  
21 paragraph (A) does not include information  
22 that the Secretary determines would be sen-  
23 sitive or would otherwise negatively impact pro-  
24 gram integrity.”; and

1           (2) by adding at the end the following new  
2 paragraph:

3           “(10) ADDRESSING IMPROPER PAYMENT  
4 VULNERABILITIES.—The Secretary shall address im-  
5 proper payment vulnerabilities identified by recovery  
6 audit contractors under this subsection in a timely  
7 manner, prioritized based on the risk to the program  
8 under this title.”.

9           (c) STRENGTHENING MEDICAID PROGRAM INTEG-  
10 RITY THROUGH FLEXIBILITY.—Section 1936 of the Social  
11 Security Act (42 U.S.C. 1396u–6) is amended—

12           (1) in subsection (a), by inserting “, or other-  
13 wise,” after “entities”; and

14           (2) in subsection (e)—

15           (A) in paragraph (1), in the matter pre-  
16 ceding subparagraph (A), by inserting “(includ-  
17 ing the costs of equipment, salaries and bene-  
18 fits, and travel and training)” after “Program  
19 under this section”; and

20           (B) in paragraph (3), by striking “by 100”  
21 and inserting “by 100, or such number as de-  
22 termined necessary by the Secretary to carry  
23 out the Program under this section,”.

24           (d) ACCESS TO THE NATIONAL DIRECTORY OF NEW  
25 HIRES.—Section 453(j) of the Social Security Act (42

1 U.S.C. 653(j)) is amended by adding at the end the fol-  
2 lowing new paragraph:

3 “(12) INFORMATION COMPARISONS AND DIS-  
4 CLOSURES TO ASSIST IN ADMINISTRATION OF THE  
5 MEDICARE PROGRAM AND STATE HEALTH SUBSIDY  
6 PROGRAMS.—

7 “(A) DISCLOSURE TO THE ADMINIS-  
8 TRATOR OF THE CENTERS FOR MEDICARE &  
9 MEDICAID SERVICES.—The Administrator of  
10 the Centers for Medicare & Medicaid shall have  
11 access to the information in the National Direc-  
12 tory of New Hires for purposes of determining  
13 the eligibility of an applicant for, or enrollee in,  
14 the Medicare program under title XVIII or an  
15 applicable State health subsidy program (as de-  
16 fined in section 1413(e) of the Patient Protec-  
17 tion and Affordable Care Act (42 U.S.C.  
18 18083(e)).

19 “(B) DISCLOSURE TO THE INSPECTOR  
20 GENERAL OF THE DEPARTMENT OF HEALTH  
21 AND HUMAN SERVICES.—

22 “(i) IN GENERAL.—If the Inspector  
23 General of the Department of Health and  
24 Human Services transmits to the Secretary  
25 the names and social security account

1 numbers of individuals, the Secretary shall  
2 disclose to the Inspector General informa-  
3 tion on such individuals and their employ-  
4 ers maintained in the National Directory  
5 of New Hires.

6 “(ii) USE OF INFORMATION.—The In-  
7 spector General of the Department of  
8 Health and Human Services may use in-  
9 formation provided under clause (i) only  
10 for purposes of —

11 “(I) enforcing mandatory and  
12 permissive exclusions under title XI;  
13 or

14 “(II) evaluating the integrity of  
15 the Medicare program or an applica-  
16 ble State health subsidy program (as  
17 defined in section 1413(e) of the Pa-  
18 tient Protection and Affordable Care  
19 Act).

20 The authority under this clause is in addi-  
21 tion to any authority conferred under the  
22 Inspector General Act of 1978 (5 U.S.C.  
23 App).

24 “(C) DISCLOSURE TO STATE AGENCIES.—

1           “(i) IN GENERAL.—If, for purposes of  
2           determining the eligibility of an applicant  
3           for, or an enrollee in, an applicable State  
4           health subsidy program (as defined in sec-  
5           tion 1413(e) of the Patient Protection and  
6           Affordable Care Act (42 U.S.C. 18083(e)),  
7           a State agency responsible for admin-  
8           istering such program transmits to the  
9           Secretary the names, dates of birth, and  
10          social security account numbers of individ-  
11          uals, the Secretary shall disclose to such  
12          State agency information on such individ-  
13          uals and their employers maintained in the  
14          National Directory of New Hires, subject  
15          to this subparagraph.

16          “(ii) CONDITION ON DISCLOSURE BY  
17          THE SECRETARY.—The Secretary shall  
18          make a disclosure under clause (i) only to  
19          the extent that the Secretary determines  
20          that the disclosure would not interfere with  
21          the effective operation of the program  
22          under this part.

23          “(iii) USE AND DISCLOSURE OF IN-  
24          FORMATION BY STATE AGENCIES.—

1                   “(I) IN GENERAL.—A State  
2 agency may not use or disclose infor-  
3 mation provided under clause (i) ex-  
4 cept for purposes of determining the  
5 eligibility of an applicant for, or an  
6 enrollee in, a program referred to in  
7 clause (i).

8                   “(II) INFORMATION SECURITY.—  
9 The State agency shall have in effect  
10 data security and control policies that  
11 the Secretary finds adequate to ensure  
12 the security of information obtained  
13 under clause (i) and to ensure that  
14 access to such information is re-  
15 stricted to authorized persons for pur-  
16 poses of authorized uses and disclo-  
17 sures.

18                   “(III) PENALTY FOR MISUSE OF  
19 INFORMATION.—An officer or em-  
20 ployee of the State agency who fails to  
21 comply with this clause shall be sub-  
22 ject to the sanctions under subsection  
23 (l)(2) to the same extent as if such of-  
24 ficer or employee were an officer or  
25 employee of the United States.

1 “(iv) PROCEDURAL REQUIREMENTS.—

2 State agencies requesting information  
3 under clause (i) shall adhere to uniform  
4 procedures established by the Secretary  
5 governing information requests and data  
6 matching under this paragraph.

7 “(v) REIMBURSEMENT OF COSTS.—

8 The State agency shall reimburse the Sec-  
9 retary, in accordance with subsection  
10 (k)(3), for the costs incurred by the Sec-  
11 retary in furnishing the information re-  
12 quested under this subparagraph.”.

13 (e) IMPROVING THE SHARING OF DATA BETWEEN  
14 THE FEDERAL GOVERNMENT AND STATE MEDICAID PRO-  
15 GRAMS.—

16 (1) IN GENERAL.—The Secretary of Health and  
17 Human Services (in this subsection referred to as  
18 the “Secretary”) shall establish a plan to encourage  
19 and facilitate the participation of States in the Medi-  
20 care-Medicaid Data Match Program (commonly re-  
21 ferred to as the “Medi-Medi Program”) under sec-  
22 tion 1893(g) of the Social Security Act (42 U.S.C.  
23 1395ddd(g)).

24 (2) PROGRAM REVISIONS TO IMPROVE MEDI-  
25 MEDI DATA MATCH PROGRAM PARTICIPATION BY

1 STATES.—Section 1893(g)(1)(A) of the Social Secu-  
2 rity Act (42 U.S.C. 1395ddd(g)(1)(A)) is amend-  
3 ed—

4 (A) in the matter preceding clause (i), by  
5 inserting “or otherwise” after “eligible enti-  
6 ties”;

7 (B) in clause (i)—

8 (i) by inserting “to review claims  
9 data” after “algorithms”; and

10 (ii) by striking “service, time, or pa-  
11 tient” and inserting “provider, service,  
12 time, or patient”;

13 (C) in clause (ii)—

14 (i) by inserting “to investigate and re-  
15 cover amounts with respect to suspect  
16 claims” after “appropriate actions”; and

17 (ii) by striking “; and” and inserting  
18 a semicolon;

19 (D) in clause (iii), by striking the period  
20 and inserting “; and”; and

21 (E) by adding at end the following new  
22 clause:

23 “(iv) furthering the Secretary’s de-  
24 sign, development, installation, or enhance-



ment of an automated data system architecture—

“(I) to collect, integrate, and assess data for purposes of program integrity, program oversight, and administration, including the Medi-Medi Program; and

“(II) that improves the coordination of requests for data from States.”.

(3) PROVIDING STATES WITH DATA ON IMPROPER PAYMENTS MADE FOR ITEMS OR SERVICES PROVIDED TO DUAL ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—The Secretary shall develop and implement a plan that allows each State agency responsible for administering a State plan for medical assistance under title XIX of the Social Security Act access to relevant data on improper or fraudulent payments made under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for health care items or services provided to dual eligible individuals.

(B) DUAL ELIGIBLE INDIVIDUAL DEFINED.—In this paragraph, the term “dual eli-

gible individual” means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), or enrolled for benefits under part B of title XVIII of such Act (42 U.S.C. 1395j et seq.), and is eligible for medical assistance under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or under a waiver of such plan.

## **TITLE IV—OTHER PROVISIONS**

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

(a) FINDINGS.—Congress finds the following:

(1) In order to elevate the role of patient choices in the health care system, the American public must engage in an informed, national, public debate on how the current health care system empowers and informs health care decision-making, and what can be done to improve the likelihood patients receive the care they want and need.

(2) Research suggests that patients often do not receive the care they want. As a result, the end of life is associated with a substantial burden of suffering by the patient and negative health and finan-

1        cial consequences that extend to family members and  
2        society.

3            (3) Patients face a complex and fragmented  
4        health care system that may decrease the likelihood  
5        that health care choices are known and carried out.  
6        The health care system should embed principles that  
7        take into account patient wishes.

8            (4) Decisions concerning health care, including  
9        end-of-life issues, affect an increasing number of  
10       Americans.

11           (5) Medical advances are prolonging life expect-  
12       ancy in the United States both in acute life-threat-  
13       ening situations and protracted battles with illness.  
14       These advances raise new challenges surrounding  
15       health care decision-making.

16           (6) The United States health care system  
17       should promote consideration of a person's pref-  
18       erence in health care decision-making and end-of-life  
19       choices.

20        (b) COMMISSION.—The Social Security Act is amend-  
21       ed by inserting after section 1150B (42 U.S.C. 1320b–  
22       24) the following new section:

1 **“SEC. 1150C. COMMISSION ON IMPROVING PATIENT DI-**  
2 **RECTED HEALTH CARE.**

3 “(a) PURPOSES.—The purposes of this section are  
4 to—

5 “(1) provide a forum for a nationwide public  
6 debate on improving patient self-determination in  
7 health care decision-making;

8 “(2) identify strategies that ensure every Amer-  
9 ican has the health care they want; and

10 “(3) provide recommendations to Congress that  
11 result from the debate.

12 “(b) ESTABLISHMENT.—The Secretary shall estab-  
13 lish an entity to be known as the Commission on Improv-  
14 ing Patient Directed Health Care (referred to in this sec-  
15 tion as the ‘Commission’).

16 “(c) MEMBERSHIP.—

17 “(1) NUMBER AND APPOINTMENT.—The Com-  
18 mission shall be composed of 15 members. One  
19 member shall be the Secretary. The Comptroller  
20 General of the United States shall appoint 14 mem-  
21 bers.

22 “(2) QUALIFICATIONS.—The membership of the  
23 Commission shall include—

24 “(A) health care consumers impacted by  
25 decision-making in advance of a health care cri-  
26 sis, such as individuals of advanced age, indi-

1           viduals with chronic, terminal and mental ill-  
 2           nesses, family care givers, and individuals with  
 3           disabilities;

4           “(B) providers in settings where crucial  
 5           health care decision-making occurs, such as  
 6           those working in intensive care settings, emer-  
 7           gency room departments, primary care settings,  
 8           nursing homes, hospice, or palliative care set-  
 9           tings;

10          “(C) payors ensuring patients get the level  
 11          of care they want;

12          “(D) experts in advance care planning,  
 13          hospice, palliative care, information technology,  
 14          bioethics, aging policy, disability policy, pedi-  
 15          atric ethics, cultural sensitivity, psychology, and  
 16          health care financing;

17          “(E) individuals who represent culturally  
 18          diverse perspectives on patient self-determina-  
 19          tion and end-of-life issues; and

20          “(F) members of the faith community.

21          “(d) PERIOD OF APPOINTMENT.—Members of the  
 22          Commission shall be appointed for the life of the Commis-  
 23          sion. Any vacancies shall not affect the power and duties  
 24          of the Commission but shall be filled in the same manner  
 25          as the original appointment.

1       “(e) DESIGNATION OF THE CHAIRPERSON.—Not  
 2 later than 15 days after the date on which all members  
 3 of the Commission have been appointed, the Comptroller  
 4 General shall designate the chairperson of the Commis-  
 5 sion.

6       “(f) SUBCOMMITTEES.—The Commission may estab-  
 7 lish subcommittees if doing so increases the efficiency of  
 8 the Commission in completing tasks.

9       “(g) DUTIES.—

10           “(1) HEARINGS.—Not later than 90 days after  
 11 the date of designation of the chairperson under  
 12 subsection (e), the Commission shall hold no fewer  
 13 than 8 hearings to examine—

14                   “(A) the current state of health care deci-  
 15 sion-making and advance care planning laws in  
 16 the United States at the Federal level and  
 17 across the States, as well as options for improv-  
 18 ing advance care planning tools, especially with  
 19 regard to use, portability, and storage;

20                   “(B) consumer-focused approaches that  
 21 educate the American public about patient  
 22 choices, care planning, and other end-of-life  
 23 issues;

24                   “(C) the use of comprehensive, patient-cen-  
 25 tered care plans by providers, the impact care

1 plans have on health care delivery and spend-  
2 ing, and methods to expand the use of high  
3 quality care planning tools in both public and  
4 private health care systems;

5 “(D) the role of electronic medical records  
6 and other technologies in improving patient-di-  
7 rected health care;

8 “(E) innovative tools for improving patient  
9 experience with advanced illness, such as pallia-  
10 tive care, hospice, and other models;

11 “(F) the role social determinants of health,  
12 such as socio-economic status, play in patient  
13 self-direction in health care;

14 “(G) the use of culturally-competent tools  
15 for health care decision-making;

16 “(H) strategies for educating providers  
17 and increasing provider engagement on care  
18 planning, palliative care, hospice care, and  
19 other issues surrounding honoring patient  
20 choices;

21 “(I) the sociological and psychological fac-  
22 tors that influence health care decision-making  
23 and end-of-life choices; and

24 “(J) the role of spirituality and religion in  
25 patient self-determination in health care.

1           “(2) ADDITIONAL HEARINGS.—The Commission  
2           may hold additional hearings on subjects other than  
3           those listed in paragraph (1) so long as such hear-  
4           ings are determined necessary by the Commission in  
5           carrying out the purposes of this section. Such addi-  
6           tional hearings do not have to be completed within  
7           the time period specified but shall not delay the  
8           other activities of the Commission under this sec-  
9           tion.

10           “(3) NUMBER AND LOCATION OF HEARINGS  
11           AND ADDITIONAL HEARINGS.—The Commission shall  
12           hold no fewer than 8 hearings as indicated in para-  
13           graph (1) and in sufficient number in order to re-  
14           ceive information that reflects—

15                   “(A) the geographic differences throughout  
16                   the United States;

17                   “(B) diverse populations; and

18                   “(C) a balance among urban and rural  
19                   populations.

20           “(4) INTERACTIVE TECHNOLOGY.—The Com-  
21           mission may encourage public participation in hear-  
22           ings through interactive technology and other means  
23           as determined appropriate by the Commission.

24           “(5) REPORT TO THE AMERICAN PEOPLE ON  
25           PATIENT DIRECTED HEALTH CARE.—Not later than



1       90 days after the hearings described in paragraphs  
2       (1) and (2) are completed, the Commission shall  
3       prepare and make available to health care consumers  
4       through the Internet and other appropriate public  
5       channels, a report to be entitled, ‘Report to the  
6       American People on Patient Directed Health Care’.  
7       Such a report shall be understandable to the general  
8       public and include—

9               “(A) a summary of—

10               “(i) the hearings described in such  
11               paragraphs;

12               “(ii) how the current health care sys-  
13               tem empowers and informs decision-mak-  
14               ing in advance of a health care crisis;

15               “(iii) factors that contribute to the  
16               provision of health care that does not ad-  
17               here to patient wishes;

18               “(iv) the impact of care that does not  
19               follow patient choices, particularly at the  
20               end-of-life, on patients, families, providers,  
21               spending, and the health care system;

22               “(v) the laws surrounding advance  
23               care planning and health care decision-  
24               making including issues of portability, use,  
25               and storage;

1 “(vi) consumer-focused approaches to  
 2 education of the American public about pa-  
 3 tient choices, care planning, and other end-  
 4 of-life issues;

5 “(vii) the role of care plans in health  
 6 care decision-making;

7 “(viii) the role of providers in ensur-  
 8 ing patients receive the care they want;

9 “(ix) the role of electronic medical  
 10 records and other technologies in improv-  
 11 ing patient directed health care;

12 “(x) the impact of social determinants  
 13 on patient self-direction in health care  
 14 services;

15 “(xi) the use of culturally competent  
 16 methods for health care decision-making;

17 “(xii) the sociological and psycho-  
 18 logical factors that influence patient self-  
 19 determination; and

20 “(xiii) the role of spirituality and reli-  
 21 gion in health care decision-making and  
 22 end-of-life care;

23 “(B) best practices from communities, pro-  
 24 viders, and payors that document patient wish-

1 es and provide health care that adheres to those  
2 wishes; and

3 “(C) information on educating providers  
4 about health care decision-making and end-of-  
5 life issues.

6 “(6) INTERIM REQUIREMENTS.—Not later than  
7 180 days after the date of completion of the hear-  
8 ings, the Commission shall prepare and make avail-  
9 able to the public through the Internet and other ap-  
10 propriate public channels, an interim set of rec-  
11 ommendations on patient self-determination in  
12 health care and ways to improve and strengthen the  
13 health care system based on the information and  
14 preferences expressed at the community meetings.  
15 There shall be a 90-day public comment period on  
16 such recommendations.

17 “(h) RECOMMENDATIONS.—Not later than 120 days  
18 after the expiration of the public comment period de-  
19 scribed in subsection (g)(6), the Commission shall submit  
20 to Congress and the President a final set of recommenda-  
21 tions. The recommendations must be comprehensive and  
22 detailed. The recommendations must contain rec-  
23 ommendations or proposals for legislative or administra-  
24 tive action as the Commission deems appropriate, includ-

1 ing proposed legislative language to carry out the rec-  
2 ommendations or proposals.

3 “(i) ADMINISTRATION.—

4 “(1) EXECUTIVE DIRECTOR.—There shall be an  
5 Executive Director of the Commission who shall be  
6 appointed by the chairperson of the Commission in  
7 consultation with the members of the Commission.

8 “(2) COMPENSATION.—While serving on the  
9 business of the Commission (including travel time),  
10 a member of the Commission shall be entitled to  
11 compensation at the per diem equivalent of the rate  
12 provided for level IV of the Executive Schedule  
13 under section 5315 of title 5, United States Code,  
14 and while so serving away from home and the mem-  
15 ber’s regular place of business, a member may be al-  
16 lowed travel expenses, as authorized by the chair-  
17 person of the Commission. For purposes of pay and  
18 employment benefits, rights, and privileges, all per-  
19 sonnel of the Commission shall be treated as if they  
20 were employees of the Senate.

21 “(3) INFORMATION FROM FEDERAL AGEN-  
22 CIES.—The Commission may secure directly from  
23 any Federal department or agency such information  
24 as the Commission considers necessary to carry out  
25 this section. Upon request of the Commission the

1 head of such department or agency shall furnish  
2 such information.

3 “(4) POSTAL SERVICES.—The Commission may  
4 use the United States mails in the same manner and  
5 under the same conditions as other departments and  
6 agencies of the Federal Government.

7 “(j) DETAIL.—Not more than 4 Federal Government  
8 employees employed by the Department of Labor, 4 Fed-  
9 eral Government employees employed by the Social Secu-  
10 rity Administration, and 8 Federal Government employees  
11 employed by the Department of Health and Human Serv-  
12 ices may be detailed to the Commission under this section  
13 without further reimbursement. Any detail of an employee  
14 shall be without interruption or loss of civil service status  
15 or privilege.

16 “(k) TEMPORARY AND INTERMITTENT SERVICES.—  
17 The chairperson of the Commission may procure tem-  
18 porary and intermittent services under section 3109(b) of  
19 title 5, United States Code, at rates for individuals which  
20 do not exceed the daily equivalent of the annual rate of  
21 basic pay prescribed for level V of the Executive Schedule  
22 under section 5316 of such title.

23 “(l) ANNUAL REPORT.—Not later than 1 year after  
24 the date of enactment of this Act, and annually thereafter  
25 during the existence of the Commission, the Commission

1 shall report to Congress and make public a detailed de-  
2 scription of the expenditures of the Commission used to  
3 carry out its duties under this section.

4 “(m) SUNSET OF COMMISSION.—The Commission  
5 shall terminate on the date that is 3 years after the date  
6 on which all the members of the Commission have been  
7 appointed under subsection (c)(1) and appropriations are  
8 first made available to carry out this section.

9 “(n) ADMINISTRATION REVIEW AND COMMENTS.—  
10 Not later than 45 days after receiving the final rec-  
11 ommendations of the Commission under subsection (h),  
12 the President shall submit a report to Congress which  
13 shall contain—

14 “(1) additional views and comments on such  
15 recommendations; and

16 “(2) recommendations for such legislation and  
17 administrative action as the President considers ap-  
18 propriate.

19 “(o) AUTHORIZATION OF APPROPRIATIONS.—

20 “(1) IN GENERAL.—There are authorized to be  
21 appropriated to carry out this section, \$3,000,000  
22 for each of fiscal years 2014 and 2015.

23 “(2) REPORT TO THE AMERICAN PEOPLE ON  
24 PATIENT DIRECTED HEALTH CARE.—There are au-  
25 thorized to be appropriated for the preparation and

1 dissemination of the Report to the American People  
 2 on Patient Directed Health Care described in sub-  
 3 section (g)(5), \$1,000,000 for the fiscal year in  
 4 which the report is required to be submitted.”.

5 **SEC. 402. EXPANSION OF THE DEFINITION OF INPATIENT**  
 6 **HOSPITAL SERVICES FOR CERTAIN CANCER**  
 7 **HOSPITALS.**

8 Section 1861(b) of the Social Security Act (42 U.S.C.  
 9 1395x(b)) is amended—

10 (1) in paragraph (3)—

11 (A) by inserting “(A)” after “(3)”;

12 (B) by adding “and” after the semicolon  
 13 at the end; and

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

16 “(B) subject to the third sentence of this  
 17 subsection, with respect to a hospital that—

18 “(i) is described in section  
 19 1886(d)(1)(B)(v); and

20 “(ii) as of the date of the enactment  
 21 of the Commonsense Medicare SGR Repeal  
 22 and Beneficiary Access Improvement Act  
 23 of 2014, is located in the same building, or  
 24 on the same campus, as another hospital  
 25 (as described in sections 412.22(e) and

1           412.22(f) of title 42, Code of Federal Reg-  
 2           ulations, as in effect on such date of enact-  
 3           ment );

4           items and services described in paragraphs (1)  
 5           and (2) furnished on or after October 1, 2014,  
 6           by such hospital described in section  
 7           1886(d)(1)(B)(v) or by others under arrange-  
 8           ments with them made by the hospital;”;

9           (2) by adding at the end the following new  
 10          flush sentence:

11       “Paragraph (3)(B) shall only apply to payments with re-  
 12       spect to the total number of the hospital’s patient days  
 13       at any satellite of the hospital or such days at another  
 14       hospital providing services under arrangements to the hos-  
 15       pital, determined as of the date of the enactment of the  
 16       Commonsense Medicare SGR Repeal and Beneficiary Ac-  
 17       cess Improvement Act of 2014.”.

18       **SEC. 403. QUALITY MEASURES FOR CERTAIN POST-ACUTE**  
 19                               **CARE PROVIDERS RELATING TO NOTICE AND**  
 20                               **TRANSFER OF PATIENT HEALTH INFORMA-**  
 21                               **TION AND PATIENT CARE PREFERENCES.**

22       (a) DEVELOPMENT.—The Secretary of Health and  
 23       Human Services (in this section referred to as the “Sec-  
 24       retary”) shall provide for the development of one or more  
 25       quality measures under title XVIII of the Social Security



1 Act (42 U.S.C. 1395 et seq.) to accurately communicate  
2 the existence and provide for the transfer of patient health  
3 information and patient care preferences when an indi-  
4 vidual transitions from a hospital to return home or move  
5 to other post-acute care settings.

6 (b) USE OF MEASURE DEVELOPERS.—The Secretary  
7 shall arrange for the development of such measures by ap-  
8 propriate measure developers.

9 (c) ENDORSEMENT.—The Secretary shall arrange for  
10 such developed measures to be submitted for endorsement  
11 to a consensus-based entity as described in section  
12 1890(a) of the Social Security Act (42 U.S.C.  
13 1395aaa(a)).

14 (d) USE OF MEASURES.—The Secretary shall,  
15 through notice and comment rulemaking, use such meas-  
16 ures under the quality reporting programs with respect  
17 to—

18 (1) inpatient hospitals under section  
19 1886(b)(3)(B)(viii) of the Social Security Act (42  
20 U.S.C. 1395ww(b)(3)(B)(viii));

21 (2) skilled nursing facilities under section  
22 1888(e) of such Act (42 U.S.C. 1395yy(e));

23 (3) home health services under section  
24 1895(b)(3)(B)(v) of such Act (42 U.S.C.  
25 1395fff(b)(3)(B)(v)); and

1           (4) other providers of services (as defined in  
 2           section 1861(u) of such Act) and suppliers (as de-  
 3           fined in section 1861(d) of such Act) that the Sec-  
 4           retary determines appropriate.

5 **SEC. 404. CRITERIA FOR MEDICALLY NECESSARY, SHORT**  
 6 **INPATIENT HOSPITAL STAYS.**

7           (a) IN GENERAL.—The Secretary of Health and  
 8           Human Services shall consult with, and seek input from,  
 9           interested stakeholders to determine appropriate criteria  
 10          for payment under the Medicare program under title  
 11          XVIII of the Social Security Act of an inpatient hospital  
 12          admission that—

13               (1) is medically necessary; and

14               (2) is an inpatient hospital stay that is less  
 15          than two midnights, as described in section 412.3 of  
 16          title 42, Code of Federal Regulation, as finalized in  
 17          the final rule published by the Centers for Medicare  
 18          & Medicaid Services in the Federal Register on Au-  
 19          gust 19, 2013 (78 Federal Register 50496) entitled  
 20          “Medicare Program; Hospital Inpatient Prospective  
 21          Payment Systems for Acute Care Hospitals and the  
 22          Long-Term Care Hospital Prospective Payment Sys-  
 23          tem and Fiscal Year 2014 Rates; Quality Reporting  
 24          Requirements for Specific Providers; Hospital Con-

1       ditions of Participation; Payment Policies Related to  
2       Patient Status”.

3       (b) INTERESTED STAKEHOLDERS.—In subsection  
4 (a), the term “interested stakeholders” means the fol-  
5       lowing:

6               (1) Hospitals.

7               (2) Physicians

8               (3) Medicare administrative contractors under  
9       section 1874A of the Social Security Act (42 U.S.C.  
10      1395kk–1).

11              (4) Recovery audit contractors under section  
12      1893(h) of such Act (42 U.S.C. 1395ddd(h)).

13              (5) Other parties determined appropriate by the  
14      Secretary.

15 **SEC. 405. TRANSPARENCY OF REASONS FOR EXCLUDING**  
16 **ADDITIONAL PROCEDURES FROM THE MEDI-**  
17 **CARE AMBULATORY SURGICAL CENTER (ASC)**  
18 **APPROVED LIST.**

19       Section 1833(i)(1) of the Social Security Act (42  
20 U.S.C. 1395l(i)(1)) is amended by adding at the end the  
21 following: “In updating such lists for application in years  
22 beginning after December 31, 2014, for each procedure  
23 that was not proposed but was requested to be included  
24 on such lists during the public comment where the Sec-  
25 retary does not finalize (in the final rule updating such

1 lists) to so include, the Secretary shall describe in such  
 2 final rule the specific safety criteria for not including such  
 3 requested procedure on such lists.”.

4 **SEC. 406. SUPERVISION IN CRITICAL ACCESS HOSPITALS.**

5 (a) GENERAL SUPERVISION IN CRITICAL ACCESS  
 6 HOSPITALS.—Section 1834(g) of the Social Security Act  
 7 (42 U.S.C. 1395m(g)) is amended by adding at the end  
 8 the following new paragraph:

9 “(6) SUPERVISION.—In the case of services fur-  
 10 nished on or after the date of the enactment of this  
 11 paragraph, the level of supervision with respect to  
 12 outpatient therapeutic critical access hospital serv-  
 13 ices shall be general supervision (as defined by the  
 14 Secretary) unless the Secretary specifies otherwise  
 15 for a particular service.”.

16 (b) SUPERVISION OF CARDIAC AND PULMONARY RE-  
 17 HABILITATION PROGRAMS IN CRITICAL ACCESS HOS-  
 18 PITALS.—Section 1861(eee)(2)(B) of the Social Security  
 19 Act (42 U.S.C. 1395x(eee)(2)(B)) is amended by inserting  
 20 “(or, in the case of a critical access hospital, a physician,  
 21 or (beginning on the date of enactment of the Common-  
 22 sense Medicare SGR Repeal and Beneficiary Access Im-  
 23 provement Act of 2014) a nurse practitioner, clinical nurse  
 24 specialist, or physician assistant (as such terms are de-  
 25 fined in subsection (aa)(5)))” after “a physician”.

1 **SEC. 407. REQUIRING STATE LICENSURE OF BIDDING ENTI-**  
 2 **TIES UNDER THE COMPETITIVE ACQUISITION**  
 3 **PROGRAM FOR CERTAIN DURABLE MEDICAL**  
 4 **EQUIPMENT, PROSTHETICS, ORTHOTICS, AND**  
 5 **SUPPLIES (DMEPOS).**

6 Section 1847(a)(1) of the Social Security Act (42  
 7 U.S.C. 1395w–3(a)(1)) is amended by adding at the end  
 8 the following new subparagraph:

9 “(G) REQUIRING STATE LICENSURE OF  
 10 BIDDING ENTITIES.—With respect to rounds of  
 11 competitions beginning on or after the date of  
 12 enactment of this subparagraph, the Secretary  
 13 may only accept a bid from an entity for an  
 14 area if the entity meets applicable State licen-  
 15 sure requirements for such area for all items in  
 16 such bid for a product category.”.

17 **SEC. 408. RECOGNITION OF ATTENDING PHYSICIAN ASSIST-**  
 18 **ANTS AS ATTENDING PHYSICIANS TO SERVE**  
 19 **HOSPICE PATIENTS.**

20 (a) RECOGNITION OF ATTENDING PHYSICIAN AS-  
 21 SISTANTS AS ATTENDING PHYSICIANS TO SERVE HOS-  
 22 PICE PATIENTS.—

23 (1) IN GENERAL.—Section 1861(dd)(3)(B) of  
 24 the Social Security Act (42 U.S.C. 1395x(dd)(3)(B))  
 25 is amended—

1 (A) by striking “or nurse” and inserting “,  
2 the nurse”; and

3 (B) by inserting “, or the physician assist-  
4 ant (as defined in such subsection)” after “sub-  
5 section (aa)(5))”.

6 (2) CLARIFICATION OF HOSPICE ROLE OF PHY-  
7 SICIAN ASSISTANTS.—Section 1814(a)(7)(A)(i)(I) of  
8 the Social Security Act (42 U.S.C.  
9 1395f(a)(7)(A)(i)(I)) is amended by inserting “or a  
10 physician assistant” after “a nurse practitioner”.

11 (b) EFFECTIVE DATE.—The amendments made by  
12 this section shall apply to items and services furnished on  
13 or after October 1, 2015.

14 **SEC. 409. REMOTE PATIENT MONITORING PILOT**  
15 **PROJECTS.**

16 (a) PILOT PROJECTS.—

17 (1) IN GENERAL.—Not later than 9 months  
18 after the date of the enactment of this Act, the Sec-  
19 retary shall conduct pilot projects under title XVIII  
20 of the Social Security Act for the purpose of pro-  
21 viding incentives to home health agencies to furnish  
22 remote patient monitoring services that reduce ex-  
23 penditures under such title.

24 (2) SITE REQUIREMENTS.—

1 (A) URBAN AND RURAL.—The Secretary  
2 shall conduct the pilot projects under this sec-  
3 tion in both urban and rural areas.

4 (B) SITE IN A SMALL STATE.—The Sec-  
5 retary shall conduct at least 1 of the pilot  
6 projects in a State with a population of less  
7 than 1,000,000.

8 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE  
9 OF PROJECTS.—

10 (1) IN GENERAL.—The Secretary shall specify  
11 the criteria for identifying those Medicare bene-  
12 ficiaries who shall be considered within the scope of  
13 the pilot projects under this section for purposes of  
14 the application of subsection (c) and for the assess-  
15 ment of the effectiveness of the home health agency  
16 in achieving the objectives of this section.

17 (2) CRITERIA.—The criteria specified under  
18 paragraph (1)—

19 (A) shall include conditions and clinical  
20 circumstances, including congestive heart fail-  
21 ure, diabetes, and chronic pulmonary obstruc-  
22 tive disease, and other conditions determined  
23 appropriate by the Secretary; and

24 (B) may provide for the inclusion in the  
25 projects of Medicare beneficiaries who begin re-

1           ceiving home health services under title XVIII  
2           of the Social Security Act after the date of the  
3           implementation of the projects.

4       (c) INCENTIVES.—

5           (1) PERFORMANCE TARGETS.—The Secretary  
6           shall establish for each home health agency partici-  
7           pating in a pilot project under this section a per-  
8           formance target using one of the following meth-  
9           odologies, as determined appropriate by the Sec-  
10          retary:

11           (A) ADJUSTED HISTORICAL PERFORMANCE  
12          TARGET.—The Secretary shall establish for the  
13          agency—

14           (i) a base expenditure amount equal  
15           to the average total payments made under  
16           parts A, B, and D of title XVIII of the So-  
17           cial Security Act for Medicare beneficiaries  
18           determined to be within the scope of the  
19           pilot project in a base period determined  
20           by the Secretary; and

21           (ii) an annual per capita expenditure  
22           target for such beneficiaries, reflecting the  
23           base expenditure amount adjusted for risk,  
24           changes in costs, and growth rates.



1 (B) COMPARATIVE PERFORMANCE TAR-  
2 GET.—The Secretary shall establish for the  
3 agency a comparative performance target equal  
4 to the average total payments made under such  
5 parts A, B, and D during the pilot project for  
6 comparable individuals in the same geographic  
7 area that are not determined to be within the  
8 scope of the pilot project.

9 (2) PAYMENT.—Subject to paragraph (3), the  
10 Secretary shall pay to each home health agency par-  
11 ticipating in a pilot project a payment for each year  
12 under the pilot project equal to a 75 percent share  
13 of the total Medicare cost savings realized for such  
14 year relative to the performance target under para-  
15 graph (1).

16 (3) LIMITATION ON EXPENDITURES.—The Sec-  
17 retary shall limit payments under this section in  
18 order to ensure that the aggregate expenditures  
19 under title XVIII of the Social Security Act (includ-  
20 ing payments under this subsection) do not exceed  
21 the amount that the Secretary estimates would have  
22 been expended if the pilot projects under this section  
23 had not been implemented, including any reasonable  
24 costs incurred by the Secretary in the administration  
25 of the pilot projects.

1           (4) NO DUPLICATION IN PARTICIPATION IN  
2       SHARED SAVINGS PROGRAMS.—A home health agen-  
3       cy that participates in any of the following shall not  
4       be eligible to participate in the pilot projects under  
5       this section:

6           (A) A model tested or expanded under sec-  
7       tion 1115A of the Social Security Act (42  
8       U.S.C. 1315a) that involves shared savings  
9       under title XVIII of such Act or any other pro-  
10      gram or demonstration project that involves  
11      such shared savings.

12          (B) The independence at home medical  
13      practice demonstration program under section  
14      1866E of such Act (42 U.S.C. 1395cc–5).

15      (d) WAIVER AUTHORITY.—The Secretary may waive  
16   such provisions of titles XI and XVIII of the Social Secu-  
17   rity Act as the Secretary determines to be appropriate for  
18   the conduct of the pilot projects under this section.

19      (e) REPORT TO CONGRESS.—Not later than 3 years  
20   after the date that the first pilot project under this section  
21   is implemented, the Secretary shall submit to Congress a  
22   report on the projects. Such report shall contain—

23          (1) a detailed description of the projects, in-  
24      cluding any changes in clinical outcomes for Medi-  
25      care beneficiaries under the projects, Medicare bene-

1        ficiary satisfaction under the projects, utilization of  
2        items and services under parts A, B, and D of title  
3        XVIII of the Social Security Act by Medicare bene-  
4        ficiaries under the projects, and Medicare per-bene-  
5        ficiary and Medicare aggregate spending under the  
6        projects;

7            (2) a detailed description of issues related to  
8        the expansion of the projects under subsection (f);

9            (3) recommendations for such legislation and  
10       administrative actions as the Secretary considers ap-  
11       propriate; and

12           (4) other items considered appropriate by the  
13       Secretary.

14        (f) EXPANSION.—If the Secretary determines that  
15       any of the pilot projects under this section enhance health  
16       outcomes for Medicare beneficiaries and reduce expendi-  
17       tures under title XVIII of the Social Security Act, the Sec-  
18       retary shall initiate comparable projects in additional  
19       areas.

20        (g) PAYMENTS HAVE NO EFFECT ON OTHER MEDI-  
21       CARE PAYMENTS TO HOME HEALTH AGENCIES.—A pay-  
22       ment under this section shall have no effect on the amount  
23       of payments that a home health agency would otherwise  
24       receive under title XVIII of the Social Security Act for  
25       the provision of home health services.

1 (h) STUDY AND REPORT ON THE APPROPRIATE  
2 VALUATION FOR REMOTE PATIENT MONITORING SERV-  
3 ICES UNDER THE MEDICARE PHYSICIAN FEE SCHED-  
4 ULE.—

5 (1) STUDY.—The Secretary shall conduct a  
6 study on the appropriate valuation for remote pa-  
7 tient monitoring services under the Medicare physi-  
8 cian fee schedule under section 1848 of the Social  
9 Security Act (42 U.S.C. 1395w–4) in order to accu-  
10 rately reflect the resources involved in furnishing  
11 such services.

12 (2) REPORT.—Not later than 6 months after  
13 the date of the enactment of this Act, the Secretary  
14 shall submit to Congress a report on the study con-  
15 ducted under paragraph (1), together with such rec-  
16 ommendations as the Secretary determines appro-  
17 priate.

18 (i) DEFINITIONS.—In this section:

19 (1) HOME HEALTH AGENCY.—The term “home  
20 health agency” has the meaning given that term in  
21 section 1861(o) of the Social Security Act (42  
22 U.S.C. 1395x(o)).

23 (2) REMOTE PATIENT MONITORING SERV-  
24 ICES.—

1 (A) IN GENERAL.—The term “remote pa-  
2 tient monitoring services” means services fur-  
3 nished in the home using remote patient moni-  
4 toring technology which—

5 (i) shall include patient monitoring or  
6 patient assessment; and

7 (ii) may include in-home technology-  
8 based professional consultations, patient  
9 training services, clinical observation,  
10 treatment, and any additional services that  
11 utilize technologies specified by the Sec-  
12 retary.

13 (B) LIMITATION.—The term “remote pa-  
14 tient monitoring services” shall not include a  
15 telecommunication that consists solely of a tele-  
16 phone audio conversation, facsimile, or elec-  
17 tronic text mail between a health care profes-  
18 sional and a patient.

19 (3) REMOTE PATIENT MONITORING TECH-  
20 NOLOGY.—The term “remote patient monitoring  
21 technology” means a coordinated system that uses  
22 one or more home-based or mobile monitoring de-  
23 vices that automatically transmit vital sign data or  
24 information on activities of daily living and may in-  
25 clude responses to assessment questions collected on

1 the devices wirelessly or through a telecommuni-  
 2 cations connection to a server that complies with the  
 3 Federal regulations (concerning the privacy of indi-  
 4 vidually identifiable health information) promulgated  
 5 under section 264(c) of the Health Insurance Port-  
 6 ability and Accountability Act of 1996, as part of an  
 7 established plan of care for that patient that in-  
 8 cludes the review and interpretation of that data by  
 9 a health care professional.

10 (4) SECRETARY.—The term “Secretary” means  
 11 the Secretary of Health and Human Services.

12 **SEC. 410. COMMUNITY-BASED INSTITUTIONAL SPECIAL**  
 13 **NEEDS PLAN DEMONSTRATION PROGRAM.**

14 (a) IN GENERAL.—The Secretary of Health and  
 15 Human Services (referred to in this section as the “Sec-  
 16 retary”) shall establish a Community-Based Institutional  
 17 Special Needs Plan (CBI-SNP) demonstration program to  
 18 prevent and delay institutionalization under Medicaid  
 19 among targeted low-income Medicare beneficiaries.

20 (b) ESTABLISHMENT.—The Secretary shall enter into  
 21 agreements with not more than 5 specialized MA plans  
 22 for special needs individuals, as defined in section  
 23 1859(b)(6)(B)(i) of the Social Security Act (42 U.S.C.  
 24 1395w–28(b)(6)(B)(i)), to conduct the CBI-SNP dem-  
 25 onstration program. Under the CBI-SNP demonstration

1 program, a targeted low-income Medicare beneficiary shall  
2 receive, as supplemental benefits under section 1852(a)(3)  
3 of such Act (42 U.S.C. 1395w-22(a)(3)), long-term care  
4 services or supports that—

5 (1) the Secretary determines appropriate for  
6 the purposes of the CBI-SNP demonstration pro-  
7 gram; and

8 (2) for which payment may be made under the  
9 State plan under title XIX of such Act (42 U.S.C.  
10 1396 et seq.) of the State in which the targeted low-  
11 income Medicare beneficiary is located.

12 (c) ELIGIBLE PLANS.—To be eligible to participate  
13 in the CBI-SNP demonstration program, a specialized MA  
14 plan for special needs individuals must—

15 (1) serve special needs individuals (as defined  
16 in section 1859(b)(6)(B)(i) of the Social Security  
17 Act (42 U.S.C. 1395w-28(b)(6)(B)(i));

18 (2) have experience in offering special needs  
19 plans for nursing home-eligible, non-institutionalized  
20 Medicare beneficiaries who live in the community;

21 (3) be located in a State that the Secretary has  
22 determined will participate in the CBI-SNP dem-  
23 onstration program by agreeing to make available  
24 data necessary for purposes of conducting the inde-

1       pendent evaluation required under subsection (f);  
2       and

3           (4) meet such other criteria as the Secretary  
4       may require.

5       (d) TARGETED LOW-INCOME MEDICARE BENE-  
6 FICIARY DEFINED.—In this section, the term “targeted  
7 low-income Medicare beneficiary” means a Medicare bene-  
8 ficiary who—

9           (1) is enrolled in a specialized MA plan for spe-  
10       cial needs individuals that has been selected to par-  
11       ticipate in the CBI-SNP demonstration program;

12           (2) is a subsidy eligible individual (as defined in  
13       section 1860D–14(a)(3)(A) of the Social Security  
14       Act (42 U.S.C. 1395w–114(a)(3)(A)); and

15           (3) is unable to perform 2 or more activities of  
16       daily living (as defined in section 7702B(c)(2)(B) of  
17       the Internal Revenue Code of 1986).

18       (e) IMPLEMENTATION DEADLINE; DURATION.—The  
19 CBI-SNP demonstration program shall be implemented  
20 not later than January 1, 2016, and shall be conducted  
21 for a period of 3 years.

22       (f) INDEPENDENT EVALUATION AND REPORTS.—

23           (1) INDEPENDENT EVALUATION.—Not later  
24       than 2 years after the completion of the CBI-SNP  
25       demonstration program, the Secretary shall provide



1 for the evaluation of the CBI-SNP demonstration  
2 program by an independent third party. The evalua-  
3 tion shall determine whether the CBI-SNP dem-  
4 onstration program has improved patient care and  
5 quality of life for the targeted low-income Medicare  
6 beneficiaries participating in the CBI-SNP dem-  
7 onstration program. Specifically, the evaluation shall  
8 determine if the CBI-SNP demonstration program  
9 has—

10 (A) reduced hospitalizations or re-hos-  
11 pitalizations;

12 (B) reduced Medicaid nursing home facility  
13 stays; and

14 (C) reduced spenddown of income and as-  
15 sets for purposes of becoming eligible for Med-  
16 icaid.

17 (2) REPORTS.—Not later than 3 years after the  
18 completion of the CBI-SNP demonstration program,  
19 the Secretary shall submit to Congress a report con-  
20 taining the results of the evaluation conducted under  
21 paragraph (1), together with such recommendations  
22 for legislative or administrative action as the Sec-  
23 retary determines appropriate.

24 (g) FUNDING.—

1           (1) FUNDING FOR IMPLEMENTATION.—For  
2       purposes of carrying out the demonstration program  
3       under this section (other than the evaluation and re-  
4       port under subsection (f)), the Secretary shall pro-  
5       vide for the transfer from the Federal Hospital In-  
6       surance Trust Fund under section 1817 of the So-  
7       cial Security Act (42 U.S.C. 1395i) and the Federal  
8       Supplementary Medical Insurance Trust Fund under  
9       section 1841 of such Act (42 U.S.C. 1395t), in such  
10      proportion as the Secretary determines appropriate,  
11      of \$3,000,000 to the Centers for Medicare & Med-  
12      icaid Services Program Management Account.

13          (2) FUNDING FOR EVALUATION AND REPORT.—  
14      For purposes of carrying out the evaluation and re-  
15      port under subsection (f), the Secretary shall provide  
16      for the transfer from the Federal Hospital Insurance  
17      Trust Fund under such section 1817 and the Fed-  
18      eral Supplementary Medical Insurance Trust Fund  
19      under such section 1841, in such proportion as the  
20      Secretary determines appropriate, of \$500,000.

21          (3) AVAILABILITY.—Amounts transferred under  
22      paragraph (1) or (2) shall remain available until ex-  
23      pended.

24          (h) BUDGET NEUTRALITY.—In conducting the CBI-  
25      SNP demonstration program, the Secretary shall ensure

1 that the aggregate payments made by the Secretary do  
2 not exceed the amount which the Secretary estimates  
3 would have been expended under titles XVIII and XIX  
4 of the Social Security Act (42 U.S.C. 1395 et seq., 1396  
5 et seq.) if the CBI-SNP demonstration program had not  
6 been implemented.

7 (i) PAPERWORK REDUCTION ACT.—Chapter 35 of  
8 title 44, United States Code, shall not apply to the testing  
9 and evaluation of the CBI-SNP demonstration program  
10 under this section.

11 **SEC. 411. APPLYING CMMI WAIVER AUTHORITY TO PACE IN**  
12 **ORDER TO FOSTER INNOVATIONS.**

13 (a) CMMI WAIVER AUTHORITY.—Subsection (d)(1)  
14 of section 1115A of the Social Security Act (42 U.S.C.  
15 1315a) is amended—

16 (1) by inserting “(other than subsections  
17 (b)(1)(A) and (c)(5) of section 1894)” after  
18 “XVIII”; and

19 (2) by striking “and 1903(m)(2)(A)(iii)” and  
20 inserting “1903(m)(2)(A)(iii), and 1934 (other than  
21 subsections (b)(1)(A) and (c)(5) of such section)”.

22 (b) SENSE OF THE SENATE.—It is the sense of the  
23 Senate that the Secretary of Health and Human Services  
24 should use the waiver authority provided under the  
25 amendments made by this section to provide, in a budget

1 neutral manner, programs of all-inclusive care for the el-  
 2 derly (PACE programs) with increased operational flexi-  
 3 bility to support the ability of such programs to improve  
 4 and innovate and to reduce technical and administrative  
 5 barriers that have hindered enrollment in such programs.

6 **SEC. 412. IMPROVE AND MODERNIZE MEDICAID DATA SYS-**  
 7 **TEMS AND REPORTING.**

8 (a) IN GENERAL.—The Secretary of Health and  
 9 Human Services shall implement a strategic plan to in-  
 10 crease the usefulness of data about State Medicaid pro-  
 11 grams reported by States to the Centers for Medicare &  
 12 Medicaid Services. The strategic plan shall address  
 13 redundancies and gaps in Medicaid data systems and re-  
 14 porting through improvements to, and modernization of,  
 15 computer and data systems. Areas for improvement under  
 16 the plan shall include (but not be limited to) the following:

17 (1) The reporting of encounter data by man-  
 18 aged care plans.

19 (2) The timeliness and quality of reported data,  
 20 including enrollment data.

21 (3) The consistency of data reported from mul-  
 22 tiple sources.

23 (4) Information about State program policies.

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

1 Secretary of Health and Human Services shall submit a  
 2 report to Congress on the status of the implementation  
 3 of the strategic plan required under subsection (a).

4 (c) AUTHORIZATION OF APPROPRIATIONS.—There is  
 5 authorized to be appropriated to the Secretary of Health  
 6 and Human Services for the period of fiscal years 2015  
 7 through 2019, such sums as may be necessary to carry  
 8 out this section.

9 **SEC. 413. FAIRNESS IN MEDICAID SUPPLEMENTAL NEEDS**  
 10 **TRUSTS.**

11 (a) IN GENERAL.—Section 1917(d)(4)(A) of the So-  
 12 cial Security Act (42 U.S.C. 1396p(d)(4)(A)) is amended  
 13 by inserting “the individual,” after “for the benefit of such  
 14 individual by”.

15 (b) EFFECTIVE DATE.—The amendment made by  
 16 subsection (a) shall apply to trusts established on or after  
 17 the date of the enactment of this Act.

18 **SEC. 414. HELPING ENSURE LIFE- AND LIMB-SAVING AC-**  
 19 **CESS TO PODIATRIC PHYSICIANS.**

20 (a) INCLUDING PODIATRISTS AS PHYSICIANS UNDER  
 21 THE MEDICAID PROGRAM.—

22 (1) IN GENERAL.—Section 1905(a)(5)(A) of the  
 23 Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is  
 24 amended by striking “section 1861(r)(1)” and in-  
 25 serting “paragraphs (1) and (3) of section 1861(r)”.

1           (2) EFFECTIVE DATE.—

2           (A) IN GENERAL.—Except as provided in  
3           subparagraph (B), the amendment made by  
4           paragraph (1) shall apply to services furnished  
5           on or after the date of enactment of this Act.

6           (B) EXTENSION OF EFFECTIVE DATE FOR  
7           STATE LAW AMENDMENT.—In the case of a  
8           State plan under title XIX of the Social Secu-  
9           rity Act (42 U.S.C. 1396 et seq.) which the  
10          Secretary of Health and Human Services deter-  
11          mines requires State legislation in order for the  
12          plan to meet the additional requirement im-  
13          posed by the amendment made by paragraph  
14          (1), the State plan shall not be regarded as fail-  
15          ing to comply with the requirements of such  
16          title solely on the basis of its failure to meet  
17          these additional requirements before the first  
18          day of the first calendar quarter beginning after  
19          the close of the first regular session of the  
20          State legislature that begins after the date of  
21          enactment of this Act. For purposes of the pre-  
22          vious sentence, in the case of a State that has  
23          a 2-year legislative session, each year of the ses-  
24          sion is considered to be a separate regular ses-  
25          sion of the State legislature.

1 (b) MODIFICATIONS TO REQUIREMENTS FOR DIA-  
2 BETIC SHOES TO BE INCLUDED UNDER MEDICAL AND  
3 OTHER HEALTH SERVICES UNDER MEDICARE.—

4 (1) IN GENERAL.—Section 1861(s)(12) of the  
5 Social Security Act (42 U.S.C. 1395x(s)(12)) is  
6 amended to read as follows:

7 “(12) subject to section 4072(e) of the Omni-  
8 bus Budget Reconciliation Act of 1987, extra-depth  
9 shoes with inserts or custom molded shoes (in this  
10 paragraph referred to as ‘therapeutic shoes’) with  
11 inserts for an individual with diabetes, if—

12 “(A) the physician who is managing the in-  
13 dividual’s diabetic condition—

14 “(i) documents that the individual has  
15 diabetes;

16 “(ii) certifies that the individual is  
17 under a comprehensive plan of care related  
18 to the individual’s diabetic condition; and

19 “(iii) documents agreement with the  
20 prescribing podiatrist or other qualified  
21 physician (as established by the Secretary)  
22 that it is medically necessary for the indi-  
23 vidual to have such extra-depth shoes with  
24 inserts or custom molded shoes with in-  
25 serts;

1           “(B) the therapeutic shoes are prescribed  
2           by a podiatrist or other qualified physician (as  
3           established by the Secretary) who—

4                   “(i) examines the individual and de-  
5                   termines the medical necessity for the indi-  
6                   vidual to receive the therapeutic shoes; and

7                   “(ii) communicates in writing the  
8                   medical necessity to the physician de-  
9                   scribed in subparagraph (A) for the indi-  
10                  vidual to have therapeutic shoes along with  
11                  findings that the individual has peripheral  
12                  neuropathy with evidence of callus forma-  
13                  tion, a history of pre-ulcerative calluses, a  
14                  history of previous ulceration, foot deform-  
15                  ity, previous amputation, or poor circula-  
16                  tion; and

17                  “(C) the therapeutic shoes are fitted and  
18                  furnished by a podiatrist or other qualified sup-  
19                  plier (as established by the Secretary), such as  
20                  a pedorthist or orthotist, who is not the physi-  
21                  cian described in subparagraph (A) (unless the  
22                  Secretary finds that the physician is the only  
23                  such qualified individual in the area);”.



1           (2) EFFECTIVE DATE.—The amendment made  
2       by paragraph (1) shall apply with respect to items  
3       and services furnished on or after January 1, 2015.

4 **SEC. 415. DEMONSTRATION PROGRAMS TO IMPROVE COM-**  
5 **MUNITY MENTAL HEALTH SERVICES.**

6       (a) CRITERIA FOR CERTIFIED COMMUNITY BEHAV-  
7       IORAL HEALTH CLINICS TO PARTICIPATE IN DEM-  
8       ONSTRATION PROGRAMS.—

9           (1) PUBLICATION.—Not later than September  
10      1, 2015, the Secretary shall publish criteria for a  
11      clinic to be certified by a State as a certified com-  
12      munity behavioral health clinic for purposes of par-  
13      ticipating in a demonstration program conducted  
14      under subsection (d).

15          (2) REQUIREMENTS.—The criteria published  
16      under this subsection shall include criteria with re-  
17      spect to the following:

18           (A) STAFFING.—Staffing requirements, in-  
19      cluding criteria that staff have diverse discipli-  
20      nary backgrounds, have necessary State-re-  
21      quired license and accreditation, and are cul-  
22      turally and linguistically trained to serve the  
23      needs of the clinic’s patient population.

24           (B) AVAILABILITY AND ACCESSIBILITY OF  
25      SERVICES.—Availability and accessibility of

1 services, including crisis management services  
2 that are available and accessible 24 hours a  
3 day, the use of a sliding scale for payment, and  
4 no rejection for services or limiting of services  
5 on the basis of a patient's ability to pay or a  
6 place of residence.

7 (C) CARE COORDINATION.—Care coordina-  
8 tion, including requirements to coordinate care  
9 across settings and providers to ensure seamless  
10 transitions for patients across the full spectrum  
11 of health services including acute, chronic, and  
12 behavioral health needs. Care coordination re-  
13 quirements shall include partnerships or formal  
14 contracts with the following:

15 (i) Federally-qualified health centers  
16 (and as applicable, rural health clinics) to  
17 provide Federally-qualified health center  
18 services (and as applicable, rural health  
19 clinic services) to the extent such services  
20 are not provided directly through the cer-  
21 tified community behavioral health clinic.

22 (ii) Inpatient psychiatric facilities and  
23 substance use detoxification, post-detoxi-  
24 fication step-down services, and residential  
25 programs.

1 (iii) Other community or regional  
2 services, supports, and providers, including  
3 schools, child welfare agencies, juvenile and  
4 criminal justice agencies and facilities, In-  
5 dian Health Service youth regional treat-  
6 ment centers, State licensed and nationally  
7 accredited child placing agencies for thera-  
8 peutic foster care service, and other social  
9 and human services.

10 (iv) Department of Veterans Affairs  
11 medical centers, independent outpatient  
12 clinics, drop-in centers, and other facilities  
13 of the Department as defined in section  
14 1801 of title 38, United States Code.

15 (v) Inpatient acute care hospitals and  
16 hospital outpatient clinics.

17 (D) SCOPE OF SERVICES.—Provision (in a  
18 manner reflecting person-centered care) of the  
19 following services which, if not available directly  
20 through the certified community behavioral  
21 health clinic, are provided or referred through  
22 formal relationships with other providers:

23 (i) Crisis mental health services, in-  
24 cluding 24-hour mobile crisis teams, emer-

1 agency crisis intervention services, and cri-  
2 sis stabilization.

3 (ii) Screening, assessment, and diag-  
4 nosis, including risk assessment.

5 (iii) Patient-centered treatment plan-  
6 ning or similar processes, including risk as-  
7 sessment and crisis planning.

8 (iv) Outpatient mental health and  
9 substance use services.

10 (v) Outpatient clinic primary care  
11 screening and monitoring of key health in-  
12 dicators and health risk.

13 (vi) Targeted case management.

14 (vii) Psychiatric rehabilitation serv-  
15 ices.

16 (viii) Peer support and counselor serv-  
17 ices and family supports.

18 (ix) Intensive, community-based men-  
19 tal health care for members of the armed  
20 forces and veterans, particularly those  
21 members and veterans located in rural  
22 areas, provided the care is consistent with  
23 minimum clinical mental health guidelines  
24 promulgated by the Veterans Health Ad-  
25 ministration including clinical guidelines

1 contained in the Uniform Mental Health  
2 Services Handbook of such Administration.

3 (E) QUALITY AND OTHER REPORTING.—  
4 Reporting of encounter data, clinical outcomes  
5 data, quality data, and such other data as the  
6 Secretary requires.

7 (F) ORGANIZATIONAL AUTHORITY.—Cri-  
8 teria that a clinic be a non-profit or part of a  
9 local government behavioral health authority or  
10 operated under the authority of the Indian  
11 Health Service, an Indian tribe or tribal organi-  
12 zation pursuant to a contract, grant, coopera-  
13 tive agreement, or compact with the Indian  
14 Health Service pursuant to the Indian Self-De-  
15 termination Act (25 U.S.C. 450 et seq.), or an  
16 urban Indian organization pursuant to a grant  
17 or contract with the Indian Health Service  
18 under title V of the Indian Health Care Im-  
19 provement Act (25 U.S.C. 1601 et seq.).

20 (b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE  
21 PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRA-  
22 TION PROGRAMS.—

23 (1) IN GENERAL.—Not later than September 1,  
24 2015, the Secretary, through the Administrator of  
25 the Centers for Medicare & Medicaid Services, shall

1 issue guidance for the establishment of a prospective  
2 payment system that shall only apply to medical as-  
3 sistance for mental health services furnished by a  
4 certified community behavioral health clinic partici-  
5 pating in a demonstration program under subsection  
6 (d).

7 (2) REQUIREMENTS.—The guidance issued by  
8 the Secretary under paragraph (1) shall provide  
9 that—

10 (A) no payment shall be made for inpatient  
11 care, residential treatment, room and board ex-  
12 penses, or any other non-ambulatory services,  
13 as determined by the Secretary; and

14 (B) no payment shall be made to satellite  
15 facilities of certified community behavioral  
16 health clinics if such facilities are established  
17 after the date of enactment of this Act.

18 (c) PLANNING GRANTS.—

19 (1) IN GENERAL.—Not later than January 1,  
20 2016, the Secretary shall award planning grants to  
21 States for the purpose of developing proposals to  
22 participate in time-limited demonstration programs  
23 described in subsection (d).

24 (2) USE OF FUNDS.—A State awarded a plan-  
25 ning grant under this subsection shall—

1 (A) solicit input with respect to the devel-  
2 opment of such a demonstration program from  
3 patients, providers, and other stakeholders;

4 (B) certify clinics as certified community  
5 behavioral health clinics for purposes of partici-  
6 pating in a demonstration program conducted  
7 under subsection (d); and

8 (C) establish a prospective payment system  
9 for mental health services furnished by a cer-  
10 tified community behavioral health clinic par-  
11 ticipating in a demonstration program under  
12 subsection (d) in accordance with the guidance  
13 issued under subsection (b).

14 (d) DEMONSTRATION PROGRAMS.—

15 (1) IN GENERAL.—Not later than September 1,  
16 2017, the Secretary shall select States to participate  
17 in demonstration programs that are developed  
18 through planning grants awarded under subsection  
19 (c), meet the requirements of this subsection, and  
20 represent a diverse selection of geographic areas, in-  
21 cluding rural and underserved areas.

22 (2) APPLICATION REQUIREMENTS.—

23 (A) IN GENERAL.—The Secretary shall so-  
24 licit applications to participate in demonstration  
25 programs under this subsection solely from

1 States awarded planning grants under sub-  
2 section (c).

3 (B) REQUIRED INFORMATION.—An appli-  
4 cation for a demonstration program under this  
5 subsection shall include the following:

6 (i) The target Medicaid population to  
7 be served under the demonstration pro-  
8 gram.

9 (ii) A list of participating certified  
10 community behavioral health clinics.

11 (iii) Verification that the State has  
12 certified a participating clinic as a certified  
13 community behavioral health clinic in ac-  
14 cordance with the requirements of sub-  
15 section (b).

16 (iv) A description of the scope of the  
17 mental health services available under the  
18 State Medicaid program that will be paid  
19 for under the prospective payment system  
20 tested in the demonstration program.

21 (v) Verification that the State has  
22 agreed to pay for such services at the rate  
23 established under the prospective payment  
24 system.



1                   (vi) Such other information as the  
2                   Secretary may require relating to the dem-  
3                   onstration program including with respect  
4                   to determining the soundness of the pro-  
5                   posed prospective payment system.

6                   (3) NUMBER AND LENGTH OF DEMONSTRATION  
7                   PROGRAMS.—Not more than 8 States shall be se-  
8                   lected for 4-year demonstration programs under this  
9                   subsection.

10                  (4) REQUIREMENTS FOR SELECTING DEM-  
11                  ONSTRATION PROGRAMS.—

12                   (A) IN GENERAL.—The Secretary shall  
13                   give preference to selecting demonstration pro-  
14                   grams where participating certified community  
15                   behavioral health clinics—

16                   (i) provide the most complete scope of  
17                   services described in subsection (a)(2)(D)  
18                   to individuals eligible for medical assist-  
19                   ance under the State Medicaid program;

20                   (ii) will improve availability of, access  
21                   to, and participation in, services described  
22                   in subsection (a)(2)(D) to individuals eligi-  
23                   ble for medical assistance under the State  
24                   Medicaid program;

1 (iii) will improve availability of, access  
2 to, and participation in assisted outpatient  
3 mental health treatment in the State; or

4 (iv) demonstrate the potential to ex-  
5 pand available mental health services in a  
6 demonstration area and increase the qual-  
7 ity of such services without increasing net  
8 Federal spending.

9 (5) PAYMENT FOR MEDICAL ASSISTANCE FOR  
10 MENTAL HEALTH SERVICES PROVIDED BY CER-  
11 TIFIED COMMUNITY BEHAVIORAL HEALTH CLIN-  
12 ICS.—

13 (A) IN GENERAL.—The Secretary shall pay  
14 a State participating in a demonstration pro-  
15 gram under this subsection the Federal match-  
16 ing percentage specified in subparagraph (B)  
17 for amounts expended by the State to provide  
18 medical assistance for mental health services  
19 described in the demonstration program appli-  
20 cation in accordance with paragraph (2)(B)(iv)  
21 that are provided by certified community behav-  
22 ioral health clinics to individuals who are en-  
23 rolled in the State Medicaid program. Payments  
24 to States made under this paragraph shall be  
25 considered to have been under, and are subject

1 to the requirements of, section 1903 of the So-  
2 cial Security Act (42 U.S.C. 1396b).

3 (B) FEDERAL MATCHING PERCENTAGE.—

4 The Federal matching percentage specified in  
5 this subparagraph is with respect to medical as-  
6 sistance described in subparagraph (A) that is  
7 furnished—

8 (i) to a newly eligible individual de-  
9 scribed in paragraph (2) of section 1905(y)  
10 of the Social Security Act (42 U.S.C.  
11 1396d(y)), the matching rate applicable  
12 under paragraph (1) of that section; and

13 (ii) to an individual who is not a  
14 newly eligible individual (as so described)  
15 but who is eligible for medical assistance  
16 under the State Medicaid program, the en-  
17 hanced FMAP applicable to the State.

18 (C) LIMITATIONS.—

19 (i) IN GENERAL.—Payments shall be  
20 made under this paragraph to a State only  
21 for mental health services—

22 (I) that are described in the dem-  
23 onstration program application in ac-  
24 cordance with paragraph (2)(B)(iv);

1 (II) for which payment is avail-  
2 able under the State Medicaid pro-  
3 gram; and

4 (III) that are provided to an indi-  
5 vidual who is eligible for medical as-  
6 sistance under the State Medicaid  
7 program.

8 (ii) PROHIBITED PAYMENTS.—No  
9 payment shall be made under this para-  
10 graph—

11 (I) for inpatient care, residential  
12 treatment, room and board expenses,  
13 or any other non-ambulatory services,  
14 as determined by the Secretary; or

15 (II) with respect to payments  
16 made to satellite facilities of certified  
17 community behavioral health clinics if  
18 such facilities are established after the  
19 date of enactment of this Act.

20 (6) WAIVER OF STATEWIDENESS REQUIRE-  
21 MENT.—The Secretary shall waive section  
22 1902(a)(1) of the Social Security Act (42 U.S.C.  
23 1396a(a)(1)) (relating to statewideness) as may be  
24 necessary to conduct demonstration programs in ac-  
25 cordance with the requirements of this subsection.

(7) ANNUAL REPORTS.—

(A) IN GENERAL.—Not later than 1 year after the date on which the first State is selected for a demonstration program under this subsection, and annually thereafter, the Secretary shall submit to Congress an annual report on the use of funds provided under all demonstration programs conducted under this subsection. Each such report shall include—

(i) an assessment of access to community-based mental health services under the Medicaid program in the area or areas of a State targeted by a demonstration program compared to other areas of the State;

(ii) an assessment of the quality and scope of services provided by certified community behavioral health clinics compared to community-based mental health services provided in States not participating in a demonstration program under this subsection and in areas of a demonstration State that are not participating in the demonstration program; and

(iii) an assessment of the impact of the demonstration programs on the Fed-

1           eral and State costs of a full range of men-  
2           tal health services (including inpatient,  
3           emergency and ambulatory services).

4           (B) RECOMMENDATIONS.—Not later than  
5           December 31, 2021, the Secretary shall submit  
6           to Congress recommendations concerning  
7           whether the demonstration programs under this  
8           section should be continued, expanded, modi-  
9           fied, or terminated.

10          (e) DEFINITIONS.—In this section:

11           (1) FEDERALLY-QUALIFIED HEALTH CENTER  
12           SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER;  
13           RURAL HEALTH CLINIC SERVICES; RURAL HEALTH  
14           CLINIC.—The terms “Federally-qualified health cen-  
15           ter services”, “Federally-qualified health center”,  
16           “rural health clinic services”, and “rural health clin-  
17           ic” have the meanings given those terms in section  
18           1905(l) of the Social Security Act (42 U.S.C.  
19           1396d(l)).

20           (2) ENHANCED FMAP.—The term “enhanced  
21           FMAP” has the meaning given that term in section  
22           2105(b) of the Social Security Act (42 U.S.C.  
23           1397dd(b) but without regard to the second and  
24           third sentences of that section.

1           (3) SECRETARY.—The term “Secretary” means  
2           the Secretary of Health and Human Services.

3           (4) STATE.—The term “State” has the mean-  
4           ing given such term for purposes of title XIX of the  
5           Social Security Act (42 U.S.C. 1396 et seq.).

6           (f) FUNDING.—

7           (1) IN GENERAL.—Out of any funds in the  
8           Treasury not otherwise appropriated, there is appro-  
9           priated to the Secretary—

10                (A) for purposes of carrying out sub-  
11                sections (a), (b), and (d)(7), \$2,000,000 for fis-  
12                cal year 2014; and

13                (B) for purposes of awarding planning  
14                grants under subsection (c), \$25,000,000 for  
15                fiscal year 2016.

16           (2) AVAILABILITY.—Funds appropriated under  
17           paragraph (1) shall remain available until expended.

18 **SEC. 416. ANNUAL MEDICAID DSH REPORT.**

19           Section 1923 of the Social Security Act (42 U.S.C.  
20           1396r–4) is amended by adding at the end the following:

21           “(k) ANNUAL REPORT TO CONGRESS.—

22                “(1) IN GENERAL.—Beginning January 1,  
23                2015, and annually thereafter, the Secretary shall  
24                submit a report to Congress on the program estab-  
25                lished under this section for making payment adjust-

1       ments to disproportionate share hospitals for the  
2       purpose of providing Congress with information rel-  
3       evant to determining an appropriate level of overall  
4       funding for such payment adjustments during and  
5       after the period in which aggregate reductions in the  
6       DSH allotments to States are required under para-  
7       graphs (7) and (8) of subsection (f).

8               “(2) REQUIRED REPORT INFORMATION.—Ex-  
9       cept as otherwise provided, each report submitted  
10      under this subsection shall include the following:

11              “(A) Information and data relating to  
12              changes in the number of uninsured individuals  
13              for the most recent year for which such data  
14              are available as compared to 2013 and as com-  
15              pared to the Congressional Budget Office esti-  
16              mates of uninsured individuals made at the  
17              time of the enactment of the Patient Protection  
18              and Affordable Care Act (Public Law 111–148)  
19              and the Health Care and Education Reconcili-  
20              ation Act of 2010 (Public Law 111–152).

21              “(B) Information and data relating to the  
22              extent to which hospitals continue to incur un-  
23              compensated care costs from providing unreim-  
24              bursed or under-reimbursed services to individ-  
25              uals who either are eligible for medical assist-



1           ance under the State plan under this title or  
2           under a waiver of such plan or who have no  
3           health insurance (or other source of third party  
4           coverage) for such services.

5           “(C) Information and data relating to the  
6           extent to which hospitals continue to provide  
7           charity care and unreimbursed or under-reim-  
8           bursed services, or otherwise incur bad debt,  
9           under the program established under this title,  
10          the State Children’s Health Insurance Program  
11          established under title XXI, and State or local  
12          indigent care programs, as reported on cost re-  
13          ports submitted under title XVIII or such other  
14          data as the Secretary determines appropriate.

15          “(D) In the first report submitted under  
16          this section, a methodology for estimating the  
17          amount of unpaid patient deductibles, copay-  
18          ments and coinsurance incurred by hospitals for  
19          patients enrolled in qualified health plans  
20          through an American Health Benefits Ex-  
21          change, using existing data and minimizing the  
22          administrative burden on hospitals to the extent  
23          possible, and in subsequent reports, data re-  
24          garding such uncompensated care costs col-  
25          lected pursuant to such methodology.

1           “(E) For each State, information and data  
2 relating to the difference between the DSH al-  
3 lotment for the State for the fiscal year that  
4 began on October 1 of the year preceding the  
5 year in which the report is submitted and the  
6 aggregate amount of uncompensated care costs  
7 for all disproportionate share hospitals in the  
8 State.

9           “(F) Information and data relating to the  
10 extent to which there are certain vital hospital  
11 systems that are disproportionately experiencing  
12 high levels of uncompensated care and that  
13 have multiple other missions, such as a commit-  
14 ment to graduate medical education, the provi-  
15 sion of tertiary and trauma care services, pro-  
16 viding public health and essential community  
17 services, and providing comprehensive, coordi-  
18 nated care.

19           “(G) Such other information and data rel-  
20 evant to the determination of the level of fund-  
21 ing for, and amount of, State DSH allotments  
22 as the Secretary determines appropriate

23           “(3) AUTHORIZATION OF APPROPRIATIONS.—

24       There is authorized to be appropriated to the Sec-  
25 retary for the period of fiscal years 2015 through

1       2019, such sums as may be necessary to carry out  
2       this subsection.”.

3   **SEC. 417. IMPLEMENTATION.**

4       To the extent the Secretary of Health and Human  
5   Services issues a regulation to carry out the provisions of  
6   this Act, the Secretary shall, unless otherwise specified in  
7   this Act—

8           (1) issue a notice of proposed rulemaking that  
9       includes the proposed regulation;

10          (2) provide a period of not less than 60 cal-  
11       endar days for comments on the proposed regula-  
12       tion;

13          (3) not more than 24 months following the date  
14       of publication of the proposed rule, publish the final  
15       regulation or take alternative action (such as with-  
16       drawing the rule or proposing a revised rule with a  
17       new comment period) on the proposed regulation;  
18       and

19          (4) not less than 30 days before the effective  
20       date of the final regulation, publish the final regula-  
21       tion or take alternative action (such as withdrawing  
22       the rule or proposing a revised rule with a new com-  
23       ment period) on the proposed regulation.

1     **TITLE V—AMENDMENT TO OCO**  
2                     **ADJUSTMENTS**

3     **SEC. 501. AMENDMENT TO OCO ADJUSTMENTS.**

4             Section 251 of the Balanced Budget and Emergency  
5     Deficit Control Act of 1985 (2 U.S.C. 901) is amended—

6                     (1) in subsection (a), by striking paragraph (2)  
7             and inserting the following:

8                     “(2) **ELIMINATING A BREACH.**—

9                             “(A) **IN GENERAL.**—Each non-exempt ac-  
10             count within a category shall be reduced by a  
11             dollar amount calculated by multiplying the en-  
12             acted level of sequestrable budgetary resources  
13             in that account at that time by the uniform  
14             percentage necessary to eliminate a breach  
15             within that category.

16                             “(B) **OVERSEAS CONTINGENCIES.**—Any  
17             amount of budget authority designated as for  
18             Overseas Contingency Operations/Global War  
19             on Terrorism for any of fiscal years 2016  
20             through 2021 in excess of the levels set in sub-  
21             section (b)(2)(E) shall be counted in deter-  
22             mining whether a breach has occurred in the re-  
23             vised security category during the fiscal year.”;  
24             and

25                     (2) in subsection (b)(2)—

1 (A) in subparagraph (A)(ii), by inserting  
2 “for fiscal years 2012 through 2015,” before  
3 “the Congress”; and

4 (B) by adding at the end the following:

5 “(E) OVERSEAS CONTINGENCY OPER-  
6 ATIONS/GLOBAL WAR ON TERRORISM.—If, for  
7 fiscal years 2016 through 2021, appropriations  
8 for discretionary accounts are enacted that  
9 Congress designates for Overseas Contingency  
10 Operations/Global War on Terrorism in statute  
11 on an account by account basis and the Presi-  
12 dent subsequently so designates, the adjustment  
13 for the fiscal year shall be the total of such ap-  
14 propriations for the fiscal year in discretionary  
15 accounts designated as being for Overseas Con-  
16 tingency Operations/Global War on Terrorism,  
17 but not to exceed—

18 “(i) for fiscal year 2016,  
19 \$84,937,000,000 in additional new budget  
20 authority;

21 “(ii) for fiscal year 2017,  
22 \$77,292,000,000 in additional new budget  
23 authority;

1 “(iii) for fiscal year 2018,  
2 \$69,950,000,000 in additional new budget  
3 authority;

4 “(iv) for fiscal year 2019,  
5 \$63,304,000,000 in additional new budget  
6 authority;

7 “(v) for fiscal year 2020,  
8 \$57,227,000,000 in additional new budget  
9 authority; and

10 “(vi) for fiscal year 2021,  
11 \$51,733,000,000 in additional new budget  
12 authority.”.

13 **SEC. 502. LIMITATION ON THE USE OF OCO FUNDING.**

14 (a) IN GENERAL.—It is the sense of Congress that—

15 (1) the annual adjustments established under  
16 section 251(b)(2)(A)(ii) of the Balanced Budget and  
17 Emergency Deficit Control Act of 1985 (2 U.S.C.  
18 901(b)(2)(A)(ii)) to the statutory limits on discre-  
19 tionary spending should be reserved for programs  
20 and activities in budget functions 050 and 150 nec-  
21 essary to meet the needs of overseas contingency op-  
22 erations; and

23 (2) the requirements for designating funding as  
24 for overseas contingency operations provided for  
25 under such section should remain fully in effect.

1       (b) SAVINGS FOR DEFICIT REDUCTION.—It is the  
2 sense of the Congress that savings after the date of enact-  
3 ment of this Act from any reductions in the annual adjust-  
4 ments established under section 251(b)(2)(A)(ii) of the  
5 Balanced Budget and Emergency Deficit Control Act of  
6 1985 (2 U.S.C. 901(b)(2)(A)(ii)) should be reserved for  
7 deficit reduction only.

8       (c) RULE OF CONSTRUCTION.—Nothing in this Act  
9 shall be construed to modify or eliminate any point of  
10 order that would otherwise be available against legislation  
11 that establishes or modifies any limit or adjustment to a  
12 limit on discretionary spending.

Calendar No. 336

113<sup>TH</sup> CONGRESS  
2<sup>D</sup> Session  
**S. 2157**

**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 26, 2014

Read the second time and placed on the calendar