

Calendar No. 280

113TH CONGRESS
1ST SESSION

S. 1871

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate formula and to improve beneficiary access under the Medicare program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

DECEMBER 19, 2013

Mr. BAUCUS, from the Committee on Finance, reported the following original bill; which was read twice and placed on the calendar

A BILL

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate formula and to improve beneficiary access under the Medicare program, 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 “SGR Repeal and Medicare Beneficiary Access Act of
6 2013”.

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 quality 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 claims data availability to improve care.

TITLE II—EXTENSIONS AND OTHER PROVISIONS

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.

Subtitle D—Program Integrity

Sec. 231. Reducing improper Medicare payments.

Sec. 232. 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. 233. Improved use of funds received by the HHS Inspector General from oversight and investigative activities.
- Sec. 234. Preventing and reducing improper Medicare and Medicaid expenditures.

Subtitle E—Other Provisions

- Sec. 241. Commission on Improving Patient Directed Health Care.
- Sec. 242. Expansion of the definition of inpatient hospital services for certain cancer hospitals.
- Sec. 243. Quality measures for certain post-acute care providers relating to notice and transfer of patient health information and patient care preferences.
- Sec. 244. Criteria for medically necessary, short inpatient hospital stays.
- Sec. 245. Transparency of reasons for excluding additional procedures from the Medicare ambulatory surgical center (ASC) approved list.
- Sec. 246. Supervision in critical access hospitals.
- Sec. 247. Requiring State licensure of bidding entities under the competitive acquisition program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).
- Sec. 248. Recognition of attending physician assistants as attending physicians to serve hospice patients.
- Sec. 249. Remote patient monitoring pilot projects.
- Sec. 250. Community-Based Institutional Special Needs Plan Demonstration Program.
- Sec. 251. Applying CMMI waiver authority to PACE in order to foster innovations.
- Sec. 252. Improve and modernize Medicaid data systems and reporting.
- Sec. 253. Fairness in Medicaid supplemental needs trusts.
- Sec. 254. Helping Ensure Life- and Limb-Saving Access to Podiatric Physicians.
- Sec. 255. Demonstration program to improve community mental health services.
- Sec. 256. Annual Medicaid DSH report.
- Sec. 257. Implementation.

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

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

6 (a) STABILIZING FEE UPDATES.—

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

1 (A) in subsection (d)—

2 (i) in paragraph (1)(A), by inserting
3 “or a subsequent paragraph” after “para-
4 graph (4)”; and

5 (ii) in paragraph (4)—

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

9 (II) in subparagraph (A), by in-
10 sserting “and ending with 2013” after
11 “a year beginning with 2001”; and

12 (B) in subsection (f)—

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

16 (ii) in paragraph (2), by inserting
17 “and ending with 2013” after “beginning
18 with 2000”.

19 (2) UPDATE OF RATES FOR 2014 AND SUBSE-
20 QUENT YEARS.—Subsection (d) of section 1848 of
21 the Social Security Act (42 U.S.C. 1395w-4) is
22 amended by adding at the end the following new
23 paragraphs:

24 “(15) UPDATE FOR 2014 THROUGH 2023.—The
25 update to the single conversion factor established in

1 paragraph (1)(C) for each of 2014 through 2023
2 shall be zero percent.

3 “(16) UPDATE FOR 2024 AND SUBSEQUENT
4 YEARS.—The update to the single conversion factor
5 established in paragraph (1)(C) for 2024 and each
6 subsequent year shall be—

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

10 “(B) for other items and services, 1 per-
11 cent.”.

12 (3) MEDPAC REPORTS.—

13 (A) INITIAL REPORT.—Not later than July
14 1, 2016, the Medicare Payment Advisory Com-
15 mission shall submit to Congress a report on
16 the relationship between—

17 (i) physician and other health profes-
18 sional utilization and expenditures (and the
19 rate of increase of such utilization and ex-
20 penditures) of items and services for which
21 payment is made under section 1848 of the
22 Social Security Act (42 U.S.C. 1395w-4);
23 and

24 (ii) total utilization and expenditures
25 (and the rate of increase of such utilization

1 and expenditures) under parts A, B, and D
2 of title XVIII of such Act.

3 Such report shall include a methodology to de-
4 scribe such relationship and the impact of
5 changes in such physician and other health pro-
6 fessional practice and service ordering patterns
7 on total utilization and expenditures under
8 parts A, B, and D of such title.

9 (B) FINAL REPORT.—Not later than July
10 1, 2020, the Medicare Payment Advisory Com-
11 mission shall submit to Congress a report on
12 the relationship described in subparagraph (A),
13 including the results determined from applying
14 the methodology included in the report sub-
15 mitted under such subparagraph.

16 (b) CONSOLIDATION OF CERTAIN CURRENT LAW
17 PERFORMANCE PROGRAMS WITH NEW VALUE-BASED
18 PERFORMANCE INCENTIVE PROGRAM.—

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

21 (A) SUNSETTING SEPARATE MEANINGFUL
22 USE PAYMENT ADJUSTMENTS.—Section
23 1848(a)(7)(A) of the Social Security Act (42
24 U.S.C. 1395w-4(a)(7)(A)) is amended—

1 (i) in clause (i), by striking “or any
 2 subsequent payment year” and inserting
 3 “or 2016”;

4 (ii) in clause (ii)—

5 (I) in the matter preceding sub-
 6 clause (I), by striking “Subject to
 7 clause (iii), for” and inserting “For”;

8 (II) in subclause (I), by adding
 9 at the end “and”;

10 (III) in subclause (II), by strik-
 11 ing “; and” and inserting a period;
 12 and

13 (IV) by striking subclause (III);
 14 and

15 (iii) by striking clause (iii).

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

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

22 (I) by striking “For purposes of
 23 paragraph (1), an” and inserting
 24 “An”; and

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

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

9 “(D) CONTINUED APPLICATION FOR PUR-
10 POSES OF VBP PROGRAM.—With respect to
11 2017 and each subsequent payment year, the
12 Secretary shall, for purposes of subsection (q)
13 and in accordance with paragraph (1)(F) of
14 such subsection, determine whether an eligible
15 professional who is a VBP eligible professional
16 (as defined in subsection (q)(1)(C)) for such
17 year is a meaningful EHR user under this
18 paragraph for the performance period under
19 subsection (q) for such year.”.

20 (2) QUALITY REPORTING.—

21 (A) SUNSETTING SEPARATE QUALITY RE-
22 PORTING INCENTIVES.—Section 1848(a)(8)(A)
23 of the Social Security Act (42 U.S.C. 1395w-
24 4(a)(8)(A)) is amended—

1 (i) in clause (i), by striking “or any
2 subsequent year” and inserting “or 2016”;
3 and

4 (ii) in clause (ii)(II), by striking “and
5 each subsequent year”.

6 (B) CONTINUATION OF QUALITY MEAS-
7 URES AND PROCESSES FOR VBP PROGRAM.—
8 Section 1848 of the Social Security Act (42
9 U.S.C. 1395w-4) is amended—

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

12 “(9) CONTINUED APPLICATION FOR PURPOSES
13 OF VBP PROGRAM.—The Secretary shall, in accord-
14 ance with subsection (q)(1)(F), carry out the provi-
15 sions of this subsection for purposes of subsection
16 (q).”; and

17 (ii) in subsection (m)—

18 (I) by redesignating the para-
19 graph (7) added by section 10327(a)
20 of Public Law 111-148 as paragraph
21 (8); and

22 (II) by adding at the end the fol-
23 lowing new paragraph:

24 “(9) CONTINUED APPLICATION FOR PURPOSES
25 OF VBP PROGRAM.—The Secretary shall, in accord-

1 ance with subsection (q)(1)(F), carry out the proc-
2 esses under this subsection for purposes of sub-
3 section (q).”.

4 (3) VALUE-BASED PAYMENTS.—

5 (A) SUNSETTING SEPARATE VALUE-BASED
6 PAYMENTS.—Clause (iii) of section
7 1848(p)(4)(B) of the Social Security Act (42
8 U.S.C. 1395w–4(p)(4)(B)) is amended to read
9 as follows:

10 “(iii) APPLICATION.—The Secretary
11 shall apply the payment modifier estab-
12 lished under this subsection for items and
13 services furnished on or after January 1,
14 2015, but before January 1, 2017, with re-
15 spect to specific physicians and groups of
16 physicians the Secretary determines appro-
17 priate. Such payment modifier shall not be
18 applied for items and services furnished on
19 or after January 1, 2017.”.

20 (B) CONTINUATION OF VALUE-BASED PAY-
21 MENT MODIFIER MEASURES FOR VBP PRO-
22 GRAM.—Section 1848(p) of the Social Security
23 Act (42 U.S.C. 1395w–4(p)) is amended—

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

1 “(C) CONTINUED APPLICATION FOR PUR-
 2 POSES OF VBP PROGRAM.—The Secretary shall,
 3 in accordance with subsection (q)(1)(F), carry
 4 out subparagraph (B) for purposes of sub-
 5 section (q).”;

6 (ii) in paragraph (3), by adding at the
 7 end the following: “With respect to 2017
 8 and each subsequent year, the Secretary
 9 shall, in accordance with subsection
 10 (q)(1)(F), carry out this paragraph for
 11 purposes of subsection (q).”.

12 (c) VALUE-BASED PERFORMANCE INCENTIVE PRO-
 13 GRAM.—

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

17 “(q) VALUE-BASED PERFORMANCE INCENTIVE PRO-
 18 GRAM.—

19 “(1) ESTABLISHMENT.—

20 “(A) IN GENERAL.—Subject to the suc-
 21 ceeding provisions of this subsection, the Sec-
 22 retary shall establish an eligible professional
 23 value-based performance incentive program (in
 24 this subsection referred to as the ‘VBP pro-
 25 gram’) under which the Secretary shall—

1 “(i) develop a methodology for assess-
2 ing the total performance of each VBP eli-
3 gible professional according to performance
4 standards under paragraph (3) for a per-
5 formance period (as established under
6 paragraph (4)) for a year;

7 “(ii) using such methodology, provide
8 for a composite performance score in ac-
9 cordance with paragraph (5) for each such
10 professional for each performance period;
11 and

12 “(iii) use such composite performance
13 score of the VBP eligible professional for a
14 performance period for a year to make
15 VBP program incentive payments under
16 paragraph (7) to the professional for the
17 year.

18 “(B) PROGRAM IMPLEMENTATION.—The
19 VBP program shall apply to payments for items
20 and services furnished on or after January 1,
21 2017.

22 “(C) VBP ELIGIBLE PROFESSIONAL DE-
23 FINED.—

24 “(i) IN GENERAL.—For purposes of
25 this subsection, subject to clauses (ii) and

1 (iv), the term ‘VBP eligible professional’
2 means—

3 “(I) for the first and second
4 years for which the VBP program ap-
5 plies to payments (and for the per-
6 formance period for such first and
7 second year), a physician (as defined
8 in section 1861(r)), a physician assist-
9 ant, nurse practitioner, and clinical
10 nurse specialist (as such terms are de-
11 fined in section 1861(aa)(5)), and a
12 certified registered nurse anesthetist
13 (as defined in section 1861(bb)(2));
14 and

15 “(II) for the third year for which
16 the VBP program applies to payments
17 (and for the performance period for
18 such third year) and for each suc-
19 ceeding year (and for the performance
20 period for each such year), the profes-
21 sionals described in subclause (I) and
22 such other eligible professionals (as
23 defined in subsection (k)(3)(B)) as
24 specified by the Secretary.

1 “(ii) EXCLUSIONS.—For purposes of
2 clause (i), the term ‘VBP eligible profes-
3 sional’ does not include, with respect to a
4 year, an eligible professional (as defined in
5 subsection (k)(3)(B))—

6 “(I) who is a qualifying APM
7 participant (as defined in section
8 1833(z)(2));

9 “(II) who, subject to clause (vii),
10 is a partial qualifying APM partici-
11 pant (as defined in clause (iii)) for the
12 most recent period for which data are
13 available and who, for the perform-
14 ance period with respect to such year,
15 does not report on applicable meas-
16 ures and activities described in para-
17 graph (2)(B) that are required to be
18 reported by such a professional under
19 the VBP program; or

20 “(III) who, for the performance
21 period with respect to such year, does
22 not exceed the low-volume threshold
23 measurement selected under clause
24 (iv).

1 “(iii) PARTIAL QUALIFYING APM PAR-
2 TICIPANT.—For purposes of this subpara-
3 graph, the term ‘partial qualifying APM
4 participant’ means, with respect to a year,
5 an eligible professional for whom the Sec-
6 retary determines the minimum payment
7 percentage (or percentages), as applicable,
8 described in paragraph (2) of section
9 1833(z) for such year have not been satis-
10 fied, but who would be considered a quali-
11 fying APM participant (as defined in such
12 paragraph) for such year if—

13 “(I) with respect to 2017 and
14 2018, the reference in subparagraph
15 (A) of such paragraph to 25 percent
16 was instead a reference to 20 percent;

17 “(II) with respect to 2019 and
18 2020—

19 “(aa) the reference in sub-
20 paragraph (B)(i) of such para-
21 graph to 50 percent was instead
22 a reference to 40 percent; and

23 “(bb) the references in sub-
24 paragraph (B)(ii) of such para-
25 graph to 50 percent and 25 per-

1 cent of such paragraph were in-
2 stead references to 40 percent
3 and 20 percent, respectively; and

4 “(III) with respect to 2021 and
5 subsequent years—

6 “(aa) the reference in sub-
7 paragraph (C)(i) of such para-
8 graph to 75 percent was instead
9 a reference to 50 percent; and

10 “(bb) the references in sub-
11 paragraph (C)(ii) of such para-
12 graph to 75 percent and 25 per-
13 cent of such paragraph were in-
14 stead references to 50 percent
15 and 20 percent, respectively.

16 “(iv) SELECTION OF LOW-VOLUME
17 THRESHOLD MEASUREMENT.—The Sec-
18 retary shall select one of the following low-
19 volume threshold measurements to apply
20 for purposes of clause (ii)(III):

21 “(I) The minimum number (as
22 determined by the Secretary) of indi-
23 viduals enrolled under this part who
24 are treated by the VBP eligible pro-

1 professional for the performance period
2 involved.

3 “(II) The minimum number (as
4 determined by the Secretary) of items
5 and services furnished to individuals
6 enrolled under this part by such pro-
7 fessional for such performance period.

8 “(III) The minimum amount (as
9 determined by the Secretary) of al-
10 lowed charges billed by such profes-
11 sional under this part for such per-
12 formance period.

13 “(v) TREATMENT OF NEW MEDICARE
14 ENROLLED ELIGIBLE PROFESSIONALS.—In
15 the case of a professional who first be-
16 comes a Medicare enrolled eligible profes-
17 sional during the performance period for a
18 year (and had not previously submitted
19 claims under this title such as a person, an
20 entity, or a part of a physician group or
21 under a different billing number or tax
22 identifier), such professional shall not be
23 treated under this subsection as a VBP eli-
24 gible professional until the subsequent year

1 and performance period for such subse-
2 quent year.

3 “(vi) CLARIFICATION.—In the case of
4 items and services furnished during a year
5 by an individual who is not a VBP eligible
6 professional (including pursuant to clauses
7 (ii) and (v)) with respect to a year, in no
8 case shall a reduction under paragraph (6)
9 or a VBP program incentive payment
10 under paragraph (7) apply to such indi-
11 vidual for such year.

12 “(vii) PARTIAL QUALIFYING APM PAR-
13 TICIPANT CLARIFICATION.—In the case of
14 an eligible professional who is a partial
15 qualifying APM participant, with respect
16 to a year, and who for the performance pe-
17 riod for such year reports on applicable
18 measures and activities described in para-
19 graph (2)(B) that are required to be re-
20 ported by such a professional under the
21 VBP program, such eligible professional is
22 considered to be a VBP eligible profes-
23 sional with respect to such year.

24 “(D) APPLICATION TO GROUP PRAC-
25 TICES.—

1 “(i) IN GENERAL.—Under the VBP
2 program:

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

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

24 “(ii) ENSURING COMPREHENSIVENESS
25 OF GROUP PRACTICE ASSESSMENT.—The

1 process established under clause (i) shall to
2 the extent practicable reflect the full range
3 of items and services furnished by the
4 VBP eligible professionals in the group
5 practice involved.

6 “(iii) CLARIFICATION.—VBP eligible
7 professionals electing to be a virtual group
8 under paragraph (5)(J) shall not be con-
9 sidered VBP eligible professionals in a
10 group practice for purposes of applying
11 this subparagraph.

12 “(E) USE OF REGISTRIES.—Under the
13 VBP program, the Secretary shall encourage
14 the use of qualified clinical data registries pur-
15 suant to subsection (m)(3)(E) in carrying out
16 this subsection.

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

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

1 “(ii) not apply such provision to the
2 extent that the provision is duplicative with
3 a provision of this subsection.

4 “(2) MEASURES AND ACTIVITIES UNDER PER-
5 FORMANCE CATEGORIES.—

6 “(A) PERFORMANCE CATEGORIES.—Under
7 the VBP program, the Secretary shall use the
8 following performance categories (each of which
9 is referred to in this subsection as a perform-
10 ance category) in determining the composite
11 performance score under paragraph (5):

12 “(i) Quality.

13 “(ii) Resource use.

14 “(iii) Clinical practice improvement
15 activities.

16 “(iv) Meaningful use of certified EHR
17 technology.

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

24 “(i) QUALITY.—For the performance
25 category described in subparagraph (A)(i),

1 the quality measures established for such
2 period under subsections (k) and (m), in-
3 cluding under subsection (m)(3)(E), and
4 the measures of quality of care established
5 for such period under subsection (p)(2).

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

14 “(iii) CLINICAL PRACTICE IMPROVE-
15 MENT ACTIVITIES.—For the performance
16 category described in subparagraph
17 (A)(iii), clinical practice improvement ac-
18 tivities under subcategories specified by the
19 Secretary for such period, which shall in-
20 clude at least the following:

21 “(I) The subcategory of expanded
22 practice access, which shall include ac-
23 tivities such as same day appoint-
24 ments for urgent needs and after
25 hours access to clinician advice.

1 “(II) The subcategory of popu-
2 lation management, which shall in-
3 clude activities such as monitoring
4 health conditions of individuals to pro-
5 vide timely health care interventions
6 or participation in a qualified clinical
7 data registry.

8 “(III) The subcategory of care
9 coordination, which shall include ac-
10 tivities such as timely communication
11 of test results, timely exchange of
12 clinical information to patients and
13 other providers, and use of remote
14 monitoring or telehealth.

15 “(IV) The subcategory of bene-
16 ficiary engagement, which shall in-
17 clude activities such as the establish-
18 ment of care plans for individuals
19 with complex care needs, beneficiary
20 self-management training, and using
21 shared decision-making mechanisms.

22 “(V) The subcategory of patient
23 safety and practice assessment, such
24 as through use of clinical or surgical

1 checklists and practice assessments
2 related to maintaining certification.

3 “(VI) The subcategory of partici-
4 pation in an alternative payment
5 model (as defined in section
6 1833(z)(3)(C)).

7 In establishing activities under this clause,
8 the Secretary shall give consideration to
9 the circumstances of small practices (con-
10 sisting of 10 or fewer professionals) and
11 practices located in rural areas and in
12 health professional shortage areas (as des-
13 ignated under section 332(a)(1)(A) of the
14 Public Health Service Act).

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

21 “(C) ADDITIONAL PROVISIONS.—

22 “(i) EMPHASIZING OUTCOME MEAS-
23 URES UNDER QUALITY PERFORMANCE CAT-
24 EGORY.—In applying subparagraph (B)(i),

1 the Secretary shall, as feasible, emphasize
2 the application of outcome measures.

3 “(ii) APPLICATION OF ADDITIONAL
4 SYSTEM MEASURES.—The Secretary may
5 use measures used for a payment system
6 other than for physicians for purposes of
7 the performance category described in sub-
8 paragraph (A)(i).

9 “(iii) GLOBAL AND POPULATION-
10 BASED MEASURES.—The Secretary may
11 use global measures, such as global out-
12 come measures, and population-based
13 measures for purposes of the performance
14 category described in subparagraph (A)(i).

15 “(iv) REQUEST FOR INFORMATION
16 FOR CLINICAL PRACTICE IMPROVEMENT
17 ACTIVITIES.—In initially applying subpara-
18 graph (B)(iii), the Secretary shall use a re-
19 quest for information to solicit rec-
20 ommendations from stakeholders for iden-
21 tifying activities described in such subpara-
22 graph and specifying criteria for such ac-
23 tivities.

24 “(v) CONTRACT AUTHORITY FOR
25 CLINICAL PRACTICE IMPROVEMENT ACTIVI-

1 TIES PERFORMANCE CATEGORY.—In apply-
2 ing subparagraph (B)(iii), the Secretary
3 may contract with entities to assist the
4 Secretary in—

5 “(I) identifying activities de-
6 scribed in subparagraph (B)(iii);

7 “(II) specifying criteria for such
8 activities; and

9 “(III) determining whether a
10 VBP eligible professional meets such
11 criteria.

12 “(3) PERFORMANCE STANDARDS.—

13 “(A) ESTABLISHMENT.—Under the VBP
14 program, the Secretary shall establish perform-
15 ance standards with respect to measures and
16 activities specified under paragraph (2)(B) for
17 a performance period (as established under
18 paragraph (4)) for a year.

19 “(B) CONSIDERATIONS IN ESTABLISHING
20 STANDARDS.—In establishing such performance
21 standards with respect to measures and activi-
22 ties specified under paragraph (2)(B), the Sec-
23 retary shall take into account the following:

24 “(i) Historical performance standards.

25 “(ii) Improvement rates.

1 “(iii) The opportunity for continued
2 improvement.

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

12 “(5) COMPOSITE PERFORMANCE SCORE.—

13 “(A) IN GENERAL.—Subject to the suc-
14 ceeding provisions of this paragraph, the Sec-
15 retary shall develop a methodology for assessing
16 the total performance of each VBP eligible pro-
17 fessional according to performance standards
18 under paragraph (3) with respect to applicable
19 measures and activities specified in paragraph
20 (2)(B) with respect to each performance cat-
21 egory applicable to such professional for a per-
22 formance period (as established under para-
23 graph (4)) for a year. Using such methodology,
24 the Secretary shall provide for a composite as-
25 sessment (in this subsection referred to as the

1 ‘composite performance score’) for each such
2 professional for each performance period.

3 “(B) WEIGHTING PERFORMANCE CAT-
4 EGORIES, MEASURES, AND ACTIVITIES.—Under
5 the methodology under subparagraph (A), the
6 Secretary—

7 “(i) may assign different scoring
8 weights (including a weight of 0) for—

9 “(I) each performance category
10 based on the extent to which the cat-
11 egory is applicable to the type of eligi-
12 ble professional involved; and

13 “(II) each measure and activity
14 specified under paragraph (2)(B) with
15 respect to each such category based
16 on the extent to which the measure or
17 activity is applicable to the type of eli-
18 gible professional involved; and

19 “(ii) with respect to the performance
20 category described in paragraph
21 (2)(A)(i)—

22 “(I) shall assign a higher scoring
23 weight to outcomes measures than to
24 other measures and increase the scor-

1 ing weight for outcome measures over
2 time; and

3 “(II) may assign a higher scoring
4 weight to patient experience measures.

5 “(C) INCENTIVE TO REPORT; ENCOUR-
6 AGING USE OF CERTIFIED EHR TECHNOLOGY
7 FOR REPORTING QUALITY MEASURES.—

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

18 “(ii) ENCOURAGING USE OF CER-
19 TIFIED EHR TECHNOLOGY FOR REPORTING
20 QUALITY MEASURES.—Under the method-
21 ology established under subparagraph (A),
22 the Secretary shall—

23 “(I) encourage VBP eligible pro-
24 fessionals to report on applicable
25 measures with respect to the perform-

1 ance category described in paragraph
2 (2)(A)(i) through the use of certified
3 EHR technology; and

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

13 “(D) CLINICAL PRACTICE IMPROVEMENT
14 ACTIVITIES PERFORMANCE SCORE.—

15 “(i) RULE FOR ACCREDITATION.—A
16 VBP eligible professional who is in a prac-
17 tice that is certified as a patient-centered
18 medical home or comparable specialty
19 practice pursuant to subsection
20 (b)(8)(B)(i) with respect to a performance
21 period shall be given the highest potential
22 score for the performance category de-
23 scribed in paragraph (2)(A)(iii) for such
24 period.

1 “(ii) APM PARTICIPATION.—Partici-
2 pation by a VBP eligible professional in an
3 alternative payment model (as defined in
4 section 1833(z)(3)(C)) with respect to a
5 performance period shall earn such eligible
6 professional one-half of the highest poten-
7 tial score for the performance category de-
8 scribed in paragraph (2)(A)(iii) for such
9 performance period. Nothing in the pre-
10 vious sentence shall prevent such profes-
11 sional from earning more than one-half of
12 such highest potential score for such per-
13 formance period by performing additional
14 activities with respect to such performance
15 category.

16 “(iii) SUBCATEGORIES.—A VBP eligi-
17 ble professional shall not be required to
18 perform activities in each subcategory
19 under paragraph (2)(B)(iii) to achieve the
20 highest potential score for the performance
21 category described in paragraph (2)(A)(iii).

22 “(E) DISTRIBUTION.—The Secretary shall
23 ensure that the application of the methodology
24 developed under subparagraph (A) results in a
25 continuous distribution of performance scores,

1 which shall result in differential payments
2 under paragraph (7).

3 “(F) ACHIEVEMENT AND IMPROVEMENT.—

4 “(i) TAKING INTO ACCOUNT IMPROVE-
5 MENT.—Beginning with the second year to
6 which the VBP program applies, in addi-
7 tion to the achievement score of a VBP eli-
8 gible professional, the methodology devel-
9 oped under subparagraph (A)—

10 “(I) in the case of the perform-
11 ance score for the performance cat-
12 egory described in clauses (i) and (ii)
13 of paragraph (2)(A), shall take into
14 account the improvement of the pro-
15 fessional; and

16 “(II) in the case of performance
17 scores for other performance cat-
18 egories, may take into account the im-
19 provement of the professional.

20 “(ii) ASSIGNING HIGHER WEIGHT FOR
21 ACHIEVEMENT.—Beginning with the
22 fourth year to which the VBP program ap-
23 plies, under the methodology developed
24 under subparagraph (A), the Secretary
25 shall assign a higher scoring weight under

1 subparagraph (B) with respect to the
2 achievement score of a VBP eligible profes-
3 sional with respect to a measure or activity
4 specified under paragraph (2)(B) (or with
5 respect to such a measure or activity and
6 with respect to categories described in
7 paragraph (2)(A)) than to any improve-
8 ment score applied under clause (i) with
9 respect to such measure or activity (or
10 such measure or activity and categories).

11 “(G) WEIGHTS FOR THE PERFORMANCE
12 CATEGORIES.—

13 “(i) IN GENERAL.—Under the meth-
14 odology developed under subparagraph (A),
15 subject to clauses (ii) and (iii), the com-
16 posite performance score shall be deter-
17 mined as follows:

18 “(I) QUALITY.—Thirty percent of
19 such score shall be based on perform-
20 ance with respect to the category de-
21 scribed in clause (i) of paragraph
22 (2)(A).

23 “(II) RESOURCE USE.—Thirty
24 percent of such score shall be based
25 on performance with respect to the

1 category described in clause (ii) of
2 paragraph (2)(A).

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

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

15 “(ii) AUTHORITY TO ADJUST PER-
16 CENTAGES IN CASE OF HIGH EHR MEAN-
17 INGFUL USE ADOPTION.—In any year in
18 which the Secretary estimates that the pro-
19 portion of eligible professionals (as defined
20 in subsection (o)(5)) who are meaningful
21 EHR users (as determined under sub-
22 section (o)(2)) is 75 percent or greater, the
23 Secretary may reduce the percent applica-
24 ble under clause (i)(IV), but not below 15
25 percent. If the Secretary makes such re-

1 duction for a year, the percentages applica-
2 ble under one or more of subclauses (I),
3 (II), and (III) of clause (i) for such year
4 shall be increased in a manner such that
5 the total percentage points of the increase
6 under this clause for such year equals the
7 total number of percentage points reduced
8 under the preceding sentence for such
9 year.

10 “(iii) AUTHORITY TO ADJUST PER-
11 CENTAGES FOR QUALITY AND RESOURCE
12 USE.—

13 “(I) IN GENERAL.—Subject to
14 subclause (II), the percentages de-
15 scribed in subclauses (I) and (II) of
16 clause (i), including after application
17 of clause (ii), shall be equal.

18 “(II) EXCEPTION.—For the first
19 2 years for which the VBP program
20 applies, after application of clause (ii),
21 the Secretary may increase the per-
22 centage applicable under subclause (I)
23 or (II) of clause (i) as long as the
24 Secretary decreases the percentage
25 applicable under the other subclause

1 by an equal number of percentage
2 points and the number of percentage
3 points applicable under each of sub-
4 clauses (I) and (II) is not less than
5 15.

6 “(H) RESOURCE USE.—Analysis of the
7 performance category described in paragraph
8 (2)(A)(ii) shall include results from the method-
9 ology described in subsection (r)(5), as appro-
10 priate.

11 “(I) INCLUSION OF QUALITY MEASURE
12 DATA FROM MULTIPLE PAYERS.—In applying
13 subsections (k), (m), and (p) with respect to
14 measures described in paragraph (2)(B)(i),
15 analysis of the performance category described
16 in paragraph (2)(A)(i) may include data sub-
17 mitted by VBP eligible professionals with re-
18 spect to multiple payers.

19 “(J) USE OF VOLUNTARY VIRTUAL
20 GROUPS FOR CERTAIN ASSESSMENT PUR-
21 POSES.—

22 “(i) IN GENERAL.—In the case of
23 VBP eligible professionals electing to be a
24 virtual group under clause (ii) with respect
25 to a performance period for a year, for

1 purposes of applying the methodology
2 under subparagraph (A)—

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

14 “(II) the composite score pro-
15 vided under this paragraph for such
16 performance period with respect to
17 each such performance category for
18 each such VBP eligible professional in
19 such virtual group shall be based on
20 the assessment of the combined per-
21 formance under subclause (I) for the
22 performance category and perform-
23 ance period.

24 “(ii) ELECTION OF PRACTICES TO BE
25 A VIRTUAL GROUP.—The Secretary shall,

1 in accordance with clause (iii), establish
2 and have in place a process to allow an in-
3 dividual VBP eligible professional or a
4 group practice consisting of not more than
5 10 VBP eligible professionals to elect, with
6 respect to a performance period for a year,
7 for such individual VBP eligible profes-
8 sional or all such VBP eligible profes-
9 sionals in such group practice, respectively,
10 to be a virtual group under this subpara-
11 graph with at least one other such indi-
12 vidual VBP eligible professional or group
13 practice making such an election.

14 “(iii) REQUIREMENTS.—The process
15 under clause (ii) shall provide that—

16 “(I) an election under such
17 clause, with respect to a performance
18 period, shall be made before the be-
19 ginning of such performance period
20 and may not be changed during such
21 performance period; and

22 “(II) a practice described in such
23 clause, and each VBP eligible profes-
24 sional in such practice, may elect to

1 be in no more than one virtual group
2 for a performance period.

3 “(6) FUNDING FOR VBP PROGRAM INCENTIVE
4 PAYMENTS.—

5 “(A) TOTAL AMOUNT FOR INCENTIVE PAY-
6 MENTS.—The total amount for VBP program
7 incentive payments under paragraph (7) for all
8 VBP eligible professionals for a year shall be
9 equal to the total amount of the performance
10 funding pool for all VBP eligible professionals
11 under subparagraph (B) for such year, as esti-
12 mated by the Secretary.

13 “(B) PERFORMANCE FUNDING POOL.—

14 “(i) IN GENERAL.—In the case of
15 items and services furnished by a VBP eli-
16 gible professional during a year (beginning
17 with 2017), the otherwise applicable fee
18 schedule amount (as defined in clause (iii))
19 with respect to such items and services and
20 eligible professional for such year shall be
21 reduced by the applicable percent under
22 clause (ii). The total amount of such re-
23 ductions for a year shall be referred to in
24 this subsection as the ‘performance fund-
25 ing pool’ for such year.

1 “(ii) APPLICABLE PERCENT DE-
2 FINED.—For purposes of clause (i), the
3 term ‘applicable percent’ means—

4 “(I) for 2017, 4 percent;
5 “(II) for 2018, 6 percent;
6 “(III) for 2019, 8 percent;
7 “(IV) for 2020, 10 percent; and
8 “(V) for 2021 and subsequent
9 years, a percent specified by the Sec-
10 retary (but in no case less than 10
11 percent or more than 12 percent).

12 “(iii) OTHERWISE APPLICABLE FEE
13 SCHEDULE AMOUNT.—For purposes of this
14 subparagraph and paragraph (7), the term
15 ‘otherwise applicable fee schedule amount’
16 means, with respect to items and services
17 furnished by a VBP eligible professional
18 during a year, the fee schedule amount for
19 such items and services and year that
20 would otherwise apply (without application
21 of this subparagraph or paragraph (7))
22 with respect to such eligible professional
23 under subsection (b), after application of
24 subsection (a)(3), or under another fee
25 schedule under this part.

1 “(7) VBP PROGRAM INCENTIVE PAYMENTS.—

2 “(A) VBP PROGRAM INCENTIVE PAYMENT
3 ADJUSTMENT FACTOR.—The Secretary shall
4 specify a VBP program incentive payment ad-
5 justment factor for each VBP eligible profes-
6 sional for a year. Such VBP program incentive
7 payment adjustment factor for a VBP eligible
8 professional for a year shall be determined—

9 “(i) by the composite performance
10 score of the eligible professional for such
11 year;

12 “(ii) in a manner such that the ad-
13 justment factors specified under this sub-
14 paragraph for a year results in differential
15 payments under this paragraph reflecting
16 the full range of the distribution of com-
17 posite performance scores of VBP eligible
18 professionals determined under paragraph
19 (5)(E) for such year, with such profes-
20 sionals having higher composite perform-
21 ance scores receiving higher payment; and

22 “(iii) in a manner such that the ad-
23 justment factors specified under this sub-
24 paragraph for a year—

1 “(I) do not result in a payment
2 reduction for such year by an amount
3 that exceeds the applicable percent de-
4 scribed in paragraph (6)(B)(ii) for
5 such year; and

6 “(II) do not result in a payment
7 increase for such year by an amount
8 that exceeds the applicable percent de-
9 scribed in paragraph (6)(B)(ii) for
10 such year.

11 “(B) CALCULATION OF VBP PROGRAM IN-
12 CENTIVE PAYMENT AMOUNTS.—The VBP pro-
13 gram incentive payment amount with respect to
14 items and services furnished by a VBP eligible
15 professional during a year shall be equal to the
16 difference between—

17 “(i) the product of—

18 “(I) the VBP program incentive
19 payment adjustment factor deter-
20 mined under subparagraph (A) for
21 such VBP eligible professional for
22 such year; and

23 “(II) the otherwise applicable fee
24 schedule amount (as defined in para-
25 graph (6)(B)(iii)) with respect to such

1 items and services and eligible profes-
2 sional for such year; and

3 “(ii) the otherwise applicable fee
4 schedule amount, as reduced under para-
5 graph (6)(B), with respect to such items
6 and services, eligible professional, and
7 year.

8 The application of the preceding sentence may
9 result in the VBP program incentive payment
10 amount being 0.0 with respect to an item or
11 service furnished by a VBP eligible professional.

12 “(C) APPLICATION OF VBP PROGRAM IN-
13 CENTIVE PAYMENT AMOUNT.—In the case of
14 items and services furnished by a VBP eligible
15 professional during a year (beginning with
16 2017), the otherwise applicable fee schedule
17 amount, as reduced under paragraph (6)(B),
18 with respect to such items and services and eli-
19 gible professional for such year shall be in-
20 creased, if applicable, by the VBP program in-
21 centive payment amount determined under sub-
22 paragraph (B) with respect to such items and
23 services, professional, and year.

24 “(D) BUDGET NEUTRALITY.—In specifying
25 the VBP program incentive payment adjust-

1 ment factor for each VBP eligible professional
2 for a year under subparagraph (A), the Sec-
3 retary shall ensure that the total amount of
4 VBP program incentive payment amounts
5 under this paragraph for all VBP eligible pro-
6 fessionals in a year shall be equal to the per-
7 formance funding pool for such year under
8 paragraph (6), as estimated by the Secretary.

9 “(8) ANNOUNCEMENT OF RESULT OF ADJUST-
10 MENTS.—Under the VBP program, the Secretary
11 shall, not later than 60 days prior to the year in-
12 volved, make available to each VBP eligible profes-
13 sional the VBP program incentive payment adjust-
14 ment factor under paragraph (7) and the payment
15 reduction under paragraph (6) applicable to the eli-
16 gible professional for items and services furnished by
17 the professional in such year. The Secretary may in-
18 clude such information in the confidential feedback
19 under paragraph (13).

20 “(9) NO EFFECT IN SUBSEQUENT YEARS.—The
21 VBP program incentive payment under paragraph
22 (7) and the payment reduction under paragraph (6)
23 shall each apply only with respect to the year in-
24 volved, and the Secretary shall not take into account
25 such VBP program incentive payment or payment

1 reduction in making payments to a VBP eligible pro-
2 fessional under this part in a subsequent year.

3 “(10) PUBLIC REPORTING.—

4 “(A) IN GENERAL.—The Secretary shall,
5 in an easily understandable format, make avail-
6 able on the Physician Compare Internet website
7 under subsection (t) the following:

8 “(i) Information regarding the per-
9 formance of VBP eligible professionals
10 under the VBP program, which—

11 “(I) shall include the composite
12 score for each such VBP eligible pro-
13 fessional and the performance of each
14 such VBP eligible professional with
15 respect to each performance category;
16 and

17 “(II) may include the perform-
18 ance of each such VBP eligible profes-
19 sional with respect to each measure or
20 activity specified in paragraph (2)(B).

21 “(ii) The names of eligible profes-
22 sionals in eligible alternative payment mod-
23 els (as defined in section 1833(z)(3)(D))
24 and, to the extent feasible, the names of

1 such eligible alternative payment models
2 and performance of such models.

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

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

19 “(11) CONSULTATION.—The Secretary shall
20 consult with stakeholders in carrying out the VBP
21 program, including for the identification of measures
22 and activities under paragraph (2)(B) and the meth-
23 odologies developed under paragraphs (5)(A) and
24 (7). Such consultation shall include the use of a re-

1 quest for information or other mechanisms deter-
2 mined appropriate.

3 “(12) TECHNICAL ASSISTANCE TO SMALL PRAC-
4 TICES AND PRACTICES IN HEALTH PROFESSIONAL
5 SHORTAGE AREAS.—

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

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

23 “(ii) how to transition to the imple-
24 mentation of and participation in an alter-

1 native payment model as described in sec-
2 tion 1833(z)(3)(C).

3 “(B) FUNDING FOR IMPLEMENTATION.—

4 For purposes of implementing subparagraph
5 (A), the Secretary shall provide for the transfer
6 from the Federal Supplementary Medical Insur-
7 ance Trust Fund established under section
8 1841 to the Centers for Medicare & Medicaid
9 Services Program Management Account of
10 \$25,000,000 for each of fiscal years 2014
11 through 2018. Of amounts transferred under
12 the preceding sentence, not less than
13 \$10,000,000 shall be available for technical as-
14 sistance to small practices (consisting of 10 or
15 fewer professionals) in health professional
16 shortage areas (as so designated). Amounts
17 transferred under this subparagraph for a fiscal
18 year shall be available until expended.

19 “(13) FEEDBACK AND INFORMATION TO IM-
20 PROVE PERFORMANCE.—

21 “(A) PERFORMANCE FEEDBACK.—

22 “(i) IN GENERAL.—Beginning July 1,
23 2015, the Secretary—

24 “(I) shall make available timely
25 (such as quarterly) confidential feed-

1 back to each VBP eligible professional
2 on the performance of such profes-
3 sional with respect to the performance
4 categories under clauses (i) and (ii) of
5 paragraph (2)(A); and

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

12 “(ii) MECHANISMS.—The Secretary
13 may use one or more mechanisms to make
14 feedback available under clause (i), which
15 may include use of a web-based portal or
16 other mechanisms determined appropriate
17 by the Secretary. The Secretary shall en-
18 courage provision of feedback through
19 qualified clinical data registries, as de-
20 scribed in subsection (m)(3)(E).

21 “(iii) USE OF DATA.—For purposes of
22 clause (i), the Secretary may use data,
23 with respect to a VBP eligible professional,
24 from periods prior to the current perform-
25 ance period and may use rolling periods in

1 order to make illustrative calculations
2 about the performance of such profes-
3 sional.

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

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

14 “(B) ADDITIONAL INFORMATION.—

15 “(i) IN GENERAL.—Beginning July 1,
16 2016, the Secretary shall make available to
17 each VBP eligible professional information,
18 with respect to individuals who are pa-
19 tients of such VBP eligible professional,
20 about items and services for which pay-
21 ment is made under this title that are fur-
22 nished to such individuals by other sup-
23 pliers and providers of services, which may
24 include information described in clause (ii).
25 Such information shall be made available

1 under the previous sentence to such VBP
2 eligible professionals by mechanisms deter-
3 mined appropriate by the Secretary, which
4 may include use of a web-based portal.
5 Such information shall be made available
6 in accordance with the same or similar
7 terms as data are made available to ac-
8 countable care organizations under section
9 1899, including a beneficiary opt-out.

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

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

1 types of such items and services so
2 furnished, and the dates such items
3 and services were so furnished.

4 “(II) Historical averages (and
5 other measures of the distribution if
6 appropriate) of the total, and compo-
7 nents of, allowed charges (and other
8 figures as determined appropriate by
9 the Secretary) for care episodes for
10 such period.

11 “(14) REVIEW.—

12 “(A) TARGETED REVIEW.—The Secretary
13 shall establish a process under which a VBP eli-
14 gible professional may seek an informal review
15 of the calculation of the VBP program incentive
16 payment adjustment factor applicable to such
17 eligible professional under this subsection for a
18 year. The results of a review conducted pursu-
19 ant to the previous sentence shall not be taken
20 into account for purposes of paragraph (7) with
21 respect to a year (other than with respect to the
22 calculation of such eligible professional’s VBP
23 program incentive payment adjustment factor
24 for such year) after the factors determined in

1 subparagraph (A) of such paragraph have been
2 determined for such year.

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

7 “(i) The methodology used to deter-
8 mine the amount of the VBP program in-
9 centive payment adjustment factor under
10 paragraph (7) and the determination of
11 such amount.

12 “(ii) The determination of the amount
13 of funding available for such VBP program
14 incentive payments under paragraph
15 (6)(A) and the payment reduction under
16 paragraph (6)(B)(i).

17 “(iii) The establishment of the per-
18 formance standards under paragraph (3)
19 and the performance period under para-
20 graph (4).

21 “(iv) The identification of measures
22 and activities specified under paragraph
23 (2)(B) and information made public or
24 posted on the Physician Compare Internet

1 website of the Centers for Medicare &
2 Medicaid Services under paragraph (10).

3 “(v) The methodology developed under
4 paragraph (5) that is used to calculate per-
5 formance scores and the calculation of
6 such scores, including the weighting of
7 measures and activities under such meth-
8 odology.”.

9 (2) GAO REPORTS.—

10 (A) EVALUATION OF ELIGIBLE PROFES-
11 SIONAL VBP PROGRAM.—Not later than October
12 1, 2018, and October 1, 2021, the Comptroller
13 General of the United States shall submit to
14 Congress a report evaluating the eligible profes-
15 sional value-based performance incentive pro-
16 gram under subsection (q) of section 1848 of
17 the Social Security Act (42 U.S.C. 1395w–4),
18 as added by paragraph (1). Such report shall—

19 (i) examine the distribution of the
20 performance and incentive payments for
21 VBP eligible professionals (as defined in
22 subsection (q)(1)(C) of such section) under
23 such program, and patterns relating to
24 such performance and incentive payments,
25 including those based on type of provider,

1 practice size, geographic location, and pa-
2 tient mix;

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

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

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

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

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

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

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

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

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

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

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

12 (C) STUDY TO EXAMINE RURAL AND
13 HEALTH PROFESSIONAL SHORTAGE AREA AL-
14 TERNATIVE PAYMENT MODELS.—Not later than
15 October 1, 2019, and October 1, 2021, the
16 Comptroller General of the United States shall
17 submit to Congress a report that examines the
18 transition of professionals in rural areas, health
19 professional shortage areas (as designated in
20 section 332(a)(1)(A) of the Public Health Serv-
21 ice Act), or medically underserved areas to an
22 alternative payment model (as defined in sec-
23 tion 1833(z)(3) of the Social Security Act, as
24 added by subsection (e)(1)). Such report shall
25 make recommendations for removing adminis-

1 trative barriers to practices in rural areas,
2 health professional shortage areas, and medi-
3 cally underserved areas to participation in such
4 models.

5 (3) FUNDING FOR IMPLEMENTATION.—For
6 purposes of implementing the provisions of and the
7 amendments made by this section, the Secretary of
8 Health and Human Services shall provide for the
9 transfer of \$50,000,000 from the Supplementary
10 Medical Insurance Trust Fund established under
11 section 1841 of the Social Security Act (42 U.S.C.
12 1395t) to the Centers for Medicare & Medicaid Pro-
13 gram Management Account for each of the fiscal
14 years 2014 through 2017. Amounts transferred
15 under this paragraph shall be available until ex-
16 pended.

17 (d) IMPROVING QUALITY REPORTING FOR COM-
18 POSITE SCORES.—

19 (1) CHANGES FOR GROUP REPORTING OP-
20 TION.—

21 (A) IN GENERAL.—Section
22 1848(m)(3)(C)(ii) of the Social Security Act
23 (42 U.S.C. 1395w–4(m)(3)(C)(ii)) is amended
24 by inserting “and, for 2014 and subsequent
25 years, may provide” after “shall provide”.

1 (B) CLARIFICATION OF QUALIFIED CLIN-
2 ICAL DATA REGISTRY REPORTING TO GROUP
3 PRACTICES.—Section 1848(m)(3)(D) of the So-
4 cial Security Act (42 U.S.C. 1395w-
5 4(m)(3)(D)) is amended by inserting “and, for
6 2015 and subsequent years, subparagraph (A)
7 or (C)” after “subparagraph (A)”.

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

13 (A) by striking “and subsequent years”
14 and inserting “through reporting periods occur-
15 ring in 2013”; and

16 (B) by inserting “and, for reporting peri-
17 ods occurring in 2014 and subsequent years,
18 the Secretary may establish” following “shall
19 establish”.

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

1 “(11) REPORTS ENDING WITH 2016.—Reports
2 under the Program shall not be provided after De-
3 cember 31, 2016. See subsection (q)(13) for reports
4 beginning with 2017.”.

5 (4) COORDINATION WITH SATISFYING MEANING-
6 FUL EHR USE CLINICAL QUALITY MEASURE REPORT-
7 ING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of
8 the Social Security Act (42 U.S.C. 1395w-
9 4(o)(2)(A)(iii)) is amended by inserting “and sub-
10 section (q)(5)(C)(ii)(II)” after “Subject to subpara-
11 graph (B)(ii)”.

12 (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

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

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

20 “(1) PAYMENT INCENTIVE.—

21 “(A) IN GENERAL.—In the case of covered
22 professional services furnished by an eligible
23 professional during a year that is in the period
24 beginning with 2017 and ending with 2022 and
25 for which the professional is a qualifying APM

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

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

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

1 mining actual expenditures under an alternative
2 payment model and for purposes of determining
3 or rebasing any benchmarks used under the al-
4 ternative payment model.

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

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

1 “(A) 2017 AND 2018.—With respect to
2 2017 and 2018, an eligible professional for
3 whom the Secretary determines that at least 25
4 percent of payments under this part for covered
5 professional services furnished by such profes-
6 sional during the most recent period for which
7 data are available (which may be less than a
8 year) were attributable to such services fur-
9 nished under this part through an entity that
10 participates in an eligible alternative payment
11 model with respect to such services.

12 “(B) 2019 AND 2020.—With respect to
13 2019 and 2020, an eligible professional de-
14 scribed in either of the following clauses:

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

1 participates in an eligible alternative payment
2 model with respect to such services.

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

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

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

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

1 alternative payment model is avail-
2 able under the State program
3 under that title).

4 meet the requirement described in
5 clause (iii)(I) with respect to pay-
6 ments described in item (aa) and meet
7 the requirement described in clause
8 (iii)(II) with respect to payments de-
9 scribed in item (bb);

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

22 “(III) who provides to the Sec-
23 retary such information as is nec-
24 essary for the Secretary to make a de-

1 termination under subclause (I), with
2 respect to such professional.

3 “(iii) REQUIREMENT.—For purposes
4 of clause (ii)(I)—

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

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

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

21 “(bb) certified EHR tech-
22 nology is used; and

23 “(cc) the eligible profes-
24 sional (AA) bears more than
25 nominal financial risk if actual

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

8 “(C) BEGINNING IN 2021.—With respect to
9 2021 and each subsequent year, an eligible pro-
10 fessional described in either of the following
11 clauses:

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

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

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

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

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

1 able under the State program
2 under that title.

3 meet the requirement described in
4 clause (iii)(I) with respect to pay-
5 ments described in item (aa) and meet
6 the requirement described in clause
7 (iii)(II) with respect to payments de-
8 scribed in item (bb);

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

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

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

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

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

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

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

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

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

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

8 “(A) COVERED PROFESSIONAL SERV-
9 ICES.—The term ‘covered professional services’
10 has the meaning given that term in section
11 1848(k)(3)(A).

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

15 “(C) ALTERNATIVE PAYMENT MODEL
16 (APM).—The term ‘alternative payment model’
17 means any of the following:

18 “(i) A model under section 1115A
19 (other than a health care innovation
20 award).

21 “(ii) An accountable care organization
22 under section 1899.

23 “(iii) A demonstration under section
24 1866C.

1 “(iv) A demonstration required by
2 Federal law.

3 “(D) ELIGIBLE ALTERNATIVE PAYMENT
4 MODEL (APM).—

5 “(i) IN GENERAL.—The term ‘eligible
6 alternative payment model’ means, with re-
7 spect to a year, an alternative payment
8 model—

9 “(I) that requires use of certified
10 EHR technology (as defined in sub-
11 section (o)(4));

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

18 “(III) that satisfies the require-
19 ment described in clause (ii).

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

1 “(I) is one in which one or more
2 entities bear financial risk for mone-
3 tary losses under such model that are
4 in excess of a nominal amount; or

5 “(II) is a medical home expanded
6 under section 1115A(c).

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

10 “(A) The determination that an eligible
11 professional is a qualifying APM participant
12 under paragraph (2) and the determination
13 that an alternative payment model is an eligible
14 alternative payment model under paragraph
15 (3)(D).

16 “(B) The determination of the amount of
17 the 5 percent payment incentive under para-
18 graph (1)(A), including any estimation as part
19 of such determination.”.

20 (2) COORDINATION CONFORMING AMEND-
21 MENTS.—Section 1833 of the Social Security Act
22 (42 U.S.C. 1395l) is further amended—

23 (A) in subsection (x)(3), by adding at the
24 end the following new sentence: “The amount
25 of the additional payment for a service under

1 this subsection and subsection (z) shall be de-
2 termined without regard to any additional pay-
3 ment for the service under subsection (z) and
4 this subsection, respectively.”; and

5 (B) in subsection (y)(3), by adding at the
6 end the following new sentence: “The amount
7 of the additional payment for a service under
8 this subsection and subsection (z) shall be de-
9 termined without regard to any additional pay-
10 ment for the service under subsection (z) and
11 this subsection, respectively.”.

12 (3) ENCOURAGING DEVELOPMENT AND TEST-
13 ING OF CERTAIN MODELS.—Section 1115A(b)(2) of
14 the Social Security Act (42 U.S.C. 1315a(b)(2)) is
15 amended—

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

18 “(xxi) Focusing primarily on physi-
19 cians’ services (as defined in section
20 1848(j)(3)) furnished by physicians who
21 are not primary care practitioners.

22 “(xxii) Focusing on practices of 10 or
23 fewer professionals.

24 “(xxiii) Focusing primarily on title
25 XIX, working in conjunction with the Cen-

1 ter for Medicaid and CHIP Services within
2 the Centers for Medicare & Medicaid Serv-
3 ices.”; and

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

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

19 (5) PLAN FOR INTEGRATING MEDICARE ADVAN-
20 TAGE ALTERNATIVE PAYMENT MODELS.—Not later
21 than July 1, 2015, the Secretary of Health and
22 Human Services shall submit to Congress a plan to
23 integrate Medicare Advantage alternative payment
24 models that take into account a budget neutral
25 value-based modifier.

1 (f) STUDY AND REPORT ON FRAUD RELATED TO AL-
2 TERNATIVE PAYMENT MODELS UNDER THE MEDICARE
3 PROGRAM.—

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

8 (A) examines the applicability of the Fed-
9 eral fraud prevention laws to items and services
10 furnished under title XVIII of the Social Secu-
11 rity Act for which payment is made under an
12 alternative payment model (as defined in sec-
13 tion 1833(z)(3)(C) of such Act (42 U.S.C.
14 1395l(z)(3)(C)));

15 (B) identifies aspects of such alternative
16 payment models that are vulnerable to fraudu-
17 lent activity; and

18 (C) examines the implications of waivers to
19 such laws granted in support of such alternative
20 payment models, including under any potential
21 expansion of such models.

22 (2) REPORT.—Not later than 2 years after the
23 date of the enactment of this Act, the Secretary
24 shall submit to Congress a report containing the re-
25 sults of the study conducted under paragraph (1).

1 Such report shall include recommendations for ac-
2 tions to be taken to reduce the vulnerability of such
3 alternative payment models to fraudulent activity.

4 Such report also shall include, as appropriate, rec-
5 ommendations of the Inspector General for changes
6 in Federal fraud prevention laws to reduce such vul-
7 nerability.

8 (g) IMPROVING PAYMENT ACCURACY.—

9 (1) STUDIES AND REPORTS OF EFFECT OF CER-
10 TAIN INFORMATION ON QUALITY AND RESOURCE
11 USE .—

12 (A) STUDY USING EXISTING MEDICARE
13 DATA.—

14 (i) STUDY.—The Secretary of Health
15 and Human Services (in this subsection re-
16 ferred to as the “Secretary”) shall conduct
17 a study that examines the effect of individ-
18 uals’ socioeconomic status on quality and
19 resource use outcome measures for individ-
20 uals under the Medicare program. The
21 study shall use information collected on
22 such individuals in carrying out such pro-
23 gram, such as urban and rural location,
24 eligibility for Medicaid (recognizing and ac-
25 counting for varying Medicaid eligibility

1 across States), and eligibility for benefits
2 under the supplemental security income
3 (SSI) program. The Secretary shall carry
4 out this paragraph acting through the As-
5 sistant Secretary for Planning and Evalua-
6 tion.

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

12 (B) STUDY USING OTHER DATA.—

13 (i) STUDY.—The Secretary shall con-
14 duct a study that examines the impact of
15 risk factors, such as those described in sec-
16 tion 1848(p)(3) of the Social Security Act
17 (42 U.S.C. 1395w-4(p)(3)), race, health
18 literacy, limited English proficiency (LEP),
19 and patient activation, on quality and re-
20 source use outcome measures under the
21 Medicare program. In conducting such
22 study the Secretary may use existing Fed-
23 eral data and collect such additional data
24 as may be necessary to complete the study.

1 (ii) REPORT.—Not later than 5 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 (C) EXAMINATION OF DATA IN CON-
7 DUCTING STUDIES.—In conducting the studies
8 under subparagraphs (A) and (B), the Sec-
9 retary shall examine what non-Medicare data
10 sets, such as data from the American Commu-
11 nity Survey (ACS), can be useful in conducting
12 the types of studies under such paragraphs and
13 how such data sets that are identified as useful
14 can be coordinated with Medicare administra-
15 tive data in order to improve the overall data
16 set available to do such studies and for the ad-
17 ministration of the Medicare program.

18 (D) RECOMMENDATIONS TO ACCOUNT FOR
19 INFORMATION IN PAYMENT ADJUSTMENT
20 MECHANISMS.—If the studies conducted under
21 subparagraphs (A) and (B) find a relationship
22 between the factors examined in the studies and
23 quality and resource use outcome measures,
24 then the Secretary shall also provide rec-

1 ommendations for how the Centers for Medicare
2 & Medicaid Services should—

3 (i) obtain access to the necessary data
4 (if such data is not already being collected)
5 on such factors, including recommenda-
6 tions on how to address barriers to the
7 Centers in accessing such data; and

8 (ii) account for such factors in deter-
9 mining payment adjustments based on
10 quality and resource use outcome measures
11 under the eligible professional value-based
12 performance incentive program under sec-
13 tion 1848(q) of the Social Security Act (42
14 U.S.C. 1395w-4(q)) and, as the Secretary
15 determines appropriate, other similar pro-
16 visions of title XVIII of such Act.

17 (E) FUNDING.—There are hereby appro-
18 priated from the Federal Supplemental Medical
19 Insurance Trust Fund to the Secretary to carry
20 out this paragraph \$6,000,000, to remain avail-
21 able until expended.

22 (2) CMS ACTIVITIES.—

23 (A) HIERARCHAL CONDITION CATEGORY
24 (HCC) IMPROVEMENT.—Taking into account the
25 relevant studies conducted and recommenda-

1 tions made in reports under paragraph (1), the
2 Secretary, on an ongoing basis, shall estimate
3 how an individual's health status and other risk
4 factors affect quality and resource use outcome
5 measures and, as feasible, shall incorporate in-
6 formation from quality and resource use out-
7 come measurement (including care episode and
8 patient condition groups) into the eligible pro-
9 fessional value-based performance incentive pro-
10 gram under section 1848(q) of the Social Secu-
11 rity Act and, as the Secretary determines ap-
12 propriate, other similar provisions of title XVIII
13 of such Act.

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

16 (i) IN GENERAL.—Taking into ac-
17 count the studies conducted and rec-
18 ommendations made in reports under para-
19 graph (1), the Secretary shall account for
20 identified factors (other than those applied
21 under subparagraph (A)) with an effect on
22 quality and resource use outcome measures
23 when determining payment adjustments
24 under the eligible professional value-based
25 performance incentive program under sec-

1 tion 1848(q) of the Social Security Act
2 and, as the Secretary determines appro-
3 priate, other similar provisions of title
4 XVIII of such Act.

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

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

15 (C) FUNDING.—There are hereby appro-
16 priated from the Federal Supplemental Medical
17 Insurance Trust Fund to the Secretary to carry
18 out this paragraph \$10,000,000, to remain
19 available until expended.

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

1 data on race and ethnicity for purposes of carrying
2 out the Medicare program.

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

9 “(r) COLLABORATING WITH THE PHYSICIAN, PRAC-
10 TITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO
11 IMPROVE RESOURCE USE MEASUREMENT.—

12 “(1) IN GENERAL.—In order to involve the phy-
13 sician, practitioner, and other stakeholder commu-
14 nities in enhancing the infrastructure for resource
15 use measurement, including for purposes of the
16 value-based performance incentive program under
17 subsection (q) and alternative payment models under
18 section 1833(z), the Secretary shall undertake the
19 steps described in the succeeding provisions of this
20 subsection.

21 “(2) DEVELOPMENT OF CARE EPISODE AND PA-
22 TIENT CONDITION GROUPS AND CLASSIFICATION
23 CODES.—

24 “(A) IN GENERAL.—In order to classify
25 similar patients into distinct care episode

1 groups and distinct patient condition groups,
2 the Secretary shall undertake the steps de-
3 scribed in the succeeding provisions of this
4 paragraph.

5 “(B) PUBLIC AVAILABILITY OF EXISTING
6 EFFORTS TO DESIGN AN EPISODE GROUPER.—
7 Not later than 60 days after the date of the en-
8 actment of this subsection, the Secretary shall
9 post on the Internet website of the Centers for
10 Medicare & Medicaid Services a list of the epi-
11 sode groups developed pursuant to subsection
12 (n)(9)(A) and related descriptive information.

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

23 “(i) distinct care episode groups; and

24 “(ii) distinct patient condition groups.

1 “(D) DEVELOPMENT OF PROPOSED CLAS-
2 SIFICATION CODES.—

3 “(i) IN GENERAL.—Taking into ac-
4 count the information described in sub-
5 paragraph (B) and the information re-
6 ceived under subparagraph (C), the Sec-
7 retary shall—

8 “(I) establish distinct care epi-
9 sode groups and distinct patient con-
10 dition groups, which account for at
11 least an estimated two-thirds of ex-
12 penditures under parts A and B; and

13 “(II) assign codes to such
14 groups.

15 “(ii) CARE EPISODE GROUPS.—In es-
16 tablishing the care episode groups under
17 clause (i), the Secretary shall take into ac-
18 count—

19 “(I) the patient’s clinical prob-
20 lems at the time items and services
21 are furnished during an episode of
22 care, such as the clinical conditions or
23 diagnoses, whether or not inpatient
24 hospitalization is anticipated or oc-

1 curs, and the principal procedures or
2 services planned or furnished; and

3 “(II) other factors determined
4 appropriate by the Secretary.

5 “(iii) PATIENT CONDITION GROUPS.—

6 In establishing the patient condition
7 groups under clause (i), the Secretary shall
8 take into account—

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

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

23 “(E) DRAFT CARE EPISODE AND PATIENT
24 CONDITION GROUPS AND CLASSIFICATION
25 CODES.—Not later than 120 days after the end

1 of the comment period described in subpara-
2 graph (C), the Secretary shall post on the
3 Internet website of the Centers for Medicare &
4 Medicaid Services a draft list of the care epi-
5 sode and patient condition codes established
6 under subparagraph (D) (and the criteria and
7 characteristics assigned to such code).

8 “(F) SOLICITATION OF INPUT.—The Sec-
9 retary shall seek, through the date that is 60
10 days after the Secretary posts the list pursuant
11 to subparagraph (E), comments from physician
12 specialty societies, applicable practitioner orga-
13 nizations, and other stakeholders, including in-
14 dividuals entitled to benefits under part A or
15 enrolled under this part, regarding the care epi-
16 sode and patient condition groups (and codes)
17 posted under subparagraph (E). In seeking
18 such comments, the Secretary shall use one or
19 more mechanisms (other than notice and com-
20 ment rulemaking) that may include use of open
21 door forums, town hall meetings, or other ap-
22 propriate mechanisms.

23 “(G) OPERATIONAL LIST OF CARE EPI-
24 SODE AND PATIENT CONDITION GROUPS AND
25 CODES.—Not later than 120 days after the end

1 of the comment period described in subpara-
2 graph (F), taking into account the comments
3 received under such subparagraph, the Sec-
4 retary shall post on the Internet website of the
5 Centers for Medicare & Medicaid Services an
6 operational list of care episode and patient con-
7 dition codes (and the criteria and characteris-
8 tics assigned to such code).

9 “(H) SUBSEQUENT REVISIONS.—Not later
10 than November 1 of each year (beginning with
11 2016), the Secretary shall, through rulemaking,
12 make revisions to the operational lists of care
13 episode and patient condition codes as the Sec-
14 retary determines may be appropriate. Such re-
15 visions may be based on experience, new infor-
16 mation developed pursuant to subsection
17 (n)(9)(A), and input from the physician spe-
18 cialty societies, applicable practitioner organiza-
19 tions, and other stakeholders, including individ-
20 uals entitled to benefits under part A or en-
21 rolled under this part.

22 “(3) ATTRIBUTION OF PATIENTS TO PHYSI-
23 CIANS OR PRACTITIONERS.—

24 “(A) IN GENERAL.—In order to facilitate
25 the attribution of patients and episodes (in

1 whole or in part) to one or more physicians or
2 applicable practitioners furnishing items and
3 services, the Secretary shall undertake the steps
4 described in the succeeding provisions of this
5 paragraph.

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

19 “(i) considers themselves to have the
20 primary responsibility for the general and
21 ongoing care for the patient over extended
22 periods of time;

23 “(ii) considers themselves to be the lead
24 physician or practitioner and who furnishes
25 items and services and coordinates care

1 furnished by other physicians or practi-
2 tioners for the patient during an acute epi-
3 sode;

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

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

12 “(v) furnishes items and services only
13 as ordered by another physician or practi-
14 tioner.

15 “(C) DRAFT LIST OF PATIENT RELATION-
16 SHIP CATEGORIES AND CODES.—Not later than
17 180 days after the date of the enactment of this
18 subsection, the Secretary shall post on the
19 Internet website of the Centers for Medicare &
20 Medicaid Services a draft list of the patient re-
21 lationship categories and codes developed under
22 subparagraph (B).

23 “(D) STAKEHOLDER INPUT.—The Sec-
24 retary shall seek, through the date that is 60
25 days after the Secretary posts the list pursuant

1 to subparagraph (C), comments from physician
2 specialty societies, applicable practitioner orga-
3 nizations, and other stakeholders, including in-
4 dividuals entitled to benefits under part A or
5 enrolled under this part, regarding the patient
6 relationship categories and codes posted under
7 subparagraph (C). In seeking such comments,
8 the Secretary shall use one or more mechanisms
9 (other than notice and comment rulemaking)
10 that may include open door forums, town hall
11 meetings, or other appropriate mechanisms.

12 “(E) OPERATIONAL LIST OF PATIENT RE-
13 LATIONSHIP CATEGORIES AND CODES.—Not
14 later than 120 days after the end of the com-
15 ment period described in subparagraph (D),
16 taking into account the comments received
17 under such subparagraph, the Secretary shall
18 post on the Internet website of the Centers for
19 Medicare & Medicaid Services an operational
20 list of patient relationship categories and codes.

21 “(F) SUBSEQUENT REVISIONS.—Not later
22 than November 1 of each year (beginning with
23 2016), the Secretary shall, through rulemaking,
24 make revisions to the operational list of patient
25 relationship categories and codes as the Sec-

1 retary determines appropriate. Such revisions
2 may be based on experience, new information
3 developed pursuant to subsection (n)(9)(A), and
4 input from the physician specialty societies, ap-
5 plicable practitioner organizations, and other
6 stakeholders, including individuals entitled to
7 benefits under part A or enrolled under this
8 part.

9 “(4) REPORTING OF INFORMATION FOR RE-
10 SOURCE USE MEASUREMENT.—Claims submitted for
11 items and services furnished by a physician or appli-
12 cable practitioner on or after January 1, 2016, shall,
13 as determined appropriate by the Secretary, in-
14 clude—

15 “(A) applicable codes established under
16 paragraphs (2) and (3); and

17 “(B) the national provider identifier of the
18 ordering physician or applicable practitioner (if
19 different from the billing physician or applicable
20 practitioner).

21 “(5) METHODOLOGY FOR RESOURCE USE ANAL-
22 YSIS.—

23 “(A) IN GENERAL.—In order to evaluate
24 the resources used to treat patients (with re-

1 spect to care episode and patient condition
2 groups), the Secretary shall—

3 “(i) use the patient relationship codes
4 reported on claims pursuant to paragraph
5 (4) to attribute patients (in whole or in
6 part) to one or more physicians and appli-
7 cable practitioners;

8 “(ii) use the care episode and patient
9 condition codes reported on claims pursu-
10 ant to paragraph (4) as a basis to compare
11 similar patients and care episodes and pa-
12 tient condition groups; and

13 “(iii) conduct an analysis of resource
14 use (with respect to care episodes and pa-
15 tient condition groups of such patients), as
16 the Secretary determines appropriate.

17 “(B) ANALYSIS OF PATIENTS OF PHYSI-
18 CIANS AND PRACTITIONERS.—In conducting the
19 analysis described in subparagraph (A)(iii) with
20 respect to patients attributed to physicians and
21 applicable practitioners, the Secretary shall, as
22 feasible—

23 “(i) use the claims data experience of
24 such patients by patient condition codes

1 during a common period, such as 12
2 months; and

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

5 “(I) in the case of episodes with-
6 out a hospitalization, during periods
7 of time (such as the number of days)
8 determined appropriate by the Sec-
9 retary; and

10 “(II) in the case of episodes with
11 a hospitalization, during periods of
12 time (such as the number of days) be-
13 fore, during, and after the hospitaliza-
14 tion.

15 “(C) MEASUREMENT OF RESOURCE USE.—

16 In measuring such resource use, the Sec-
17 retary—

18 “(i) shall use per patient total allowed
19 amounts for all services under part A and
20 this part (and, if the Secretary determines
21 appropriate, part D) for the analysis of pa-
22 tient resource use, by care episode codes
23 and by patient condition codes; and

24 “(ii) may, as determined appropriate,
25 use other measures of allowed amounts

1 (such as subtotals for categories of items
2 and services) and measures of utilization of
3 items and services (such as frequency of
4 specific items and services and the ratio of
5 specific items and services among attrib-
6 uted patients or episodes).

7 “(D) STAKEHOLDER INPUT.—The Sec-
8 retary shall seek comments from the physician
9 specialty societies, applicable practitioner orga-
10 nizations, and other stakeholders, including in-
11 dividuals entitled to benefits under part A or
12 enrolled under this part, regarding the resource
13 use methodology established pursuant to this
14 paragraph. In seeking comments the Secretary
15 shall use one or more mechanisms (other than
16 notice and comment rulemaking) that may in-
17 clude open door forums, town hall meetings, or
18 other appropriate mechanisms.

19 “(6) LIMITATION.—There shall be no adminis-
20 trative or judicial review under section 1869, section
21 1878, or otherwise of—

22 “(A) care episode and patient condition
23 groups and codes established under paragraph
24 (2);

1 “(B) patient relationship categories and
2 codes established under paragraph (3); and

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

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

9 “(8) DEFINITIONS.—In this section:

10 “(A) PHYSICIAN.—The term ‘physician’
11 has the meaning given such term in section
12 1861(r).

13 “(B) APPLICABLE PRACTITIONER.—The
14 term ‘applicable practitioner’ means—

15 “(i) a physician assistant, nurse prac-
16 titioner, and clinical nurse specialist (as
17 such terms are defined in section
18 1861(aa)(5)); and

19 “(ii) beginning January 1, 2017, such
20 other eligible professionals (as defined in
21 subsection (k)(3)(B)) as specified by the
22 Secretary.

23 “(9) CLARIFICATION.—The provisions of sec-
24 tions 1890A(b)(2) and 1890B shall not apply to this
25 subsection.”.

1 **SEC. 102. PRIORITIES AND FUNDING FOR QUALITY MEAS-**
2 **URE DEVELOPMENT.**

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

7 “(s) **PRIORITIES AND FUNDING FOR QUALITY MEAS-**
8 **URE DEVELOPMENT.**—

9 “(1) **PLAN IDENTIFYING MEASURE DEVELOP-**
10 **MENT PRIORITIES AND TIMELINES.**—

11 “(A) **DRAFT MEASURE DEVELOPMENT**
12 **PLAN.**—

13 “(i) **DRAFT PLAN.**—

14 “(I) **IN GENERAL.**—Not later
15 than October 1, 2014, the Secretary
16 shall develop, and post on the Internet
17 website of the Centers for Medicare &
18 Medicaid Services, a draft plan for the
19 development of quality measures for
20 application under the applicable provi-
21 sions.

22 “(II) **REQUIREMENT.**—Such plan
23 shall address how measures used by
24 private payers and integrated delivery
25 systems could be incorporated under
26 such subsection.

1 “(ii) CONSIDERATION.—In developing
2 the draft plan under subparagraph (A), the
3 Secretary shall consider—

4 “(I) gap analyses conducted by
5 the entity with a contract under sec-
6 tion 1890(a) or other contractors or
7 entities; and

8 “(II) whether measures are appli-
9 cable across health care settings.

10 “(iii) PRIORITIES.—In developing the
11 draft plan under subparagraph (A), the
12 Secretary shall give priority to the fol-
13 lowing types of measures:

14 “(I) Outcome measures including
15 patient reported outcome and func-
16 tional status measures.

17 “(II) Patient experience meas-
18 ures.

19 “(III) Care coordination meas-
20 ures.

21 “(IV) Measures of appropriate
22 use of services, including measures of
23 over use.

24 “(iv) DEFINITION OF APPLICABLE
25 PROVISIONS.—In this subsection, the term

1 ‘applicable provisions’ means the following
2 provisions:

3 “(I) Subsection (q)(2)(B)(i).

4 “(II) Section 1833(z)(2)(C).

5 “(B) STAKEHOLDER INPUT.—The Sec-
6 retary shall accept through December 1, 2014,
7 comments on the draft plan posted under para-
8 graph (1)(A) from the public, including health
9 care providers, payers, consumers, and other
10 stakeholders.

11 “(C) OPERATIONAL MEASURE DEVELOP-
12 MENT PLAN.—Not later than February 1, 2015,
13 taking into account the comments received
14 under subparagraph (B), the Secretary shall
15 post on the Internet website of the Centers for
16 Medicare & Medicaid Services an operational
17 plan for the development of quality measures
18 for use under subsection (q)(2)(A)(i).

19 “(2) CONTRACTS AND OTHER ARRANGEMENTS
20 FOR QUALITY MEASURE DEVELOPMENT.—

21 “(A) IN GENERAL.—The Secretary shall
22 enter into contracts or other arrangements with
23 entities for the purpose of developing, improv-
24 ing, updating, or expanding quality measures
25 for application under the applicable provisions.

1 Such entities may include physician specialty
2 societies and other practitioner organizations.

3 “(B) PRIORITIZATION.—

4 “(i) IN GENERAL.—In entering into
5 contracts or other arrangements under
6 subparagraph (A), the Secretary shall give
7 priority to the development of the types of
8 measures described in paragraph
9 (1)(A)(iii).

10 “(ii) CONSIDERATION.—In selecting
11 measures for development under this sub-
12 section, the Secretary shall consider wheth-
13 er such measures would be electronically
14 specified.

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

16 “(A) IN GENERAL.—Not later than Feb-
17 ruary 1, 2016, and annually thereafter, the Sec-
18 retary shall post on the Internet website of the
19 Centers for Medicare & Medicaid Services a re-
20 port on the progress made in developing quality
21 measures for application under the applicable
22 provisions.

23 “(B) REQUIREMENTS.—Each report sub-
24 mitted pursuant to paragraph (1) shall include
25 the following:

1 “(i) A description of the Secretary’s
2 efforts to implement this subsection.

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

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

10 “(II) the name of each measure
11 developed;

12 “(III) the name of the developer
13 and steward of each measure;

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

18 “(V) whether the measure would
19 be electronically specified.

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

22 “(I) the information described in
23 clause (ii), if available; and

24 “(II) a timeline for completion of
25 the development of such measures.

1 “(iv) An update on the progress in de-
2 veloping the types of measures described in
3 paragraph (1)(A)(iii), including a descrip-
4 tion of issues affecting such progress.

5 “(v) A list of quality topics and con-
6 cepts that are being considered for develop-
7 ment of measures and the rationale for the
8 selection of topics and concepts including
9 their relationship to gap analyses.

10 “(vi) A description of any updates to
11 the plan under paragraph (1) (including
12 newly identified gaps and the status of pre-
13 viously identified gaps) and the inventory
14 of measures applicable under the applicable
15 provisions.

16 “(vii) Other information the Secretary
17 determines to be appropriate.

18 “(4) STAKEHOLDER INPUT.—With respect to
19 measures applicable under the applicable provisions,
20 the Secretary shall seek stakeholder input with re-
21 spect to—

22 “(A) the identification of gaps where no
23 quality measures exist, particularly with respect
24 to the types of measures described in paragraph
25 (1)(A)(iii);

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

3 “(C) other areas related to quality measure
4 development determined appropriate by the Sec-
5 retary.

6 “(5) FUNDING.—For purposes of carrying out
7 this subsection, the Secretary shall provide for the
8 transfer, from the Federal Supplementary Medical
9 Insurance Trust Fund under section 1841, of
10 \$15,000,000 to the Centers for Medicare & Medicaid
11 Services Program Management Account for each of
12 fiscal years 2014 through 2018. Amounts trans-
13 ferred under this paragraph shall remain available
14 through the end of fiscal year 2021.”.

15 **SEC. 103. ENCOURAGING CARE MANAGEMENT FOR INDI-**
16 **VIDUALS WITH CHRONIC CARE NEEDS.**

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

20 “(8) ENCOURAGING CARE MANAGEMENT FOR
21 INDIVIDUALS WITH CHRONIC CARE NEEDS.—

22 “(A) IN GENERAL.—In order to encourage
23 the management of care by an applicable pro-
24 vider (as defined in subparagraph (B)) for indi-

1 viduals with chronic care needs the Secretary
2 shall—

3 “(i) establish one or more HCPCS
4 codes for chronic care management serv-
5 ices for such individuals; and

6 “(ii) subject to subparagraph (D),
7 make payment (as the Secretary deter-
8 mines to be appropriate) under this section
9 for such management services furnished on
10 or after January 1, 2015, by an applicable
11 provider.

12 “(B) APPLICABLE PROVIDER DEFINED.—

13 For purposes of this paragraph, the term ‘ap-
14 plicable provider’ means a physician (as defined
15 in section 1861(r)(1)), physician assistant or
16 nurse practitioner (as defined in section
17 1861(aa)(5)(A)), or clinical nurse specialist (as
18 defined in section 1861(aa)(5)(B)) who fur-
19 nishes services as part of a patient-centered
20 medical home or a comparable specialty practice
21 that—

22 “(i) is recognized as such a medical
23 home or comparable specialty practice by
24 an organization that is recognized by the

1 Secretary for purposes of such recognition
2 as such a medical home or practice; or

3 “(ii) meets such other comparable
4 qualifications as the Secretary determines
5 to be appropriate.

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

10 “(D) POLICIES RELATING TO PAYMENT.—
11 In carrying out this paragraph, with respect to
12 chronic care management services, the Sec-
13 retary shall—

14 “(i) make payment to only one appli-
15 cable provider for such services furnished
16 to an individual during a period;

17 “(ii) not make payment under sub-
18 paragraph (A) if such payment would be
19 duplicative of payment that is otherwise
20 made under this title for such services
21 (such as in the case of hospice care or
22 home health services); and

23 “(iii) not require that an annual
24 wellness visit (as defined in section
25 1861(hhh)) or an initial preventive phys-

1 ical examination (as defined in section
2 1861(ww)) be furnished as a condition of
3 payment for such management services.”.

4 (b) EDUCATION AND OUTREACH.—

5 (1) CAMPAIGN.—

6 (A) IN GENERAL.—The Secretary of
7 Health and Human Services (in this subsection
8 referred to as the “Secretary”) shall conduct an
9 education and outreach campaign to inform
10 professionals who furnish items and services
11 under part B of title XVIII of the Social Secu-
12 rity Act and individuals enrolled under such
13 part of the benefits of chronic care management
14 services described in section 1848(b)(8) of the
15 Social Security Act, as added by subsection (a),
16 and encourage such individuals with chronic
17 care needs to receive such services.

18 (B) REQUIREMENTS.—Such campaign
19 shall—

20 (i) be directed by the Office of Rural
21 Health Policy of the Department of Health
22 and Human Services and the Office of Mi-
23 nority Health of the Centers for Medicare
24 & Medicaid Services; and

1 (ii) focus on encouraging participation
2 by underserved rural populations and ra-
3 cial and ethnic minority populations.

4 (2) REPORT.—

5 (A) IN GENERAL.—Not later than Decem-
6 ber 31, 2017, the Secretary shall submit to
7 Congress a report on the use of chronic care
8 management services described in such section
9 1848(b)(8) by individuals living in rural areas
10 and by racial and ethnic minority populations.
11 Such report shall—

12 (i) identify barriers to receiving chron-
13 ic care management services; and

14 (ii) make recommendations for in-
15 creasing the appropriate use of chronic
16 care management services.

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

19 (a) AUTHORITY TO COLLECT AND USE INFORMA-
20 TION ON PHYSICIANS' SERVICES IN THE DETERMINATION
21 OF RELATIVE VALUES.—

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

1 “(M) AUTHORITY TO COLLECT AND USE
2 INFORMATION ON PHYSICIANS’ SERVICES IN
3 THE DETERMINATION OF RELATIVE VALUES.—

4 “(i) COLLECTION OF INFORMATION.—

5 Notwithstanding any other provision of
6 law, the Secretary may collect or obtain in-
7 formation on the resources directly or indi-
8 rectly related to furnishing services for
9 which payment is made under the fee
10 schedule established under subsection (b).
11 Such information may be collected or ob-
12 tained from any eligible professional or any
13 other source.

14 “(ii) USE OF INFORMATION.—Not-

15 withstanding any other provision of law,
16 subject to clause (v), the Secretary may
17 (as the Secretary determines appropriate)
18 use information collected or obtained pur-
19 suant to clause (i) in the determination of
20 relative values for services under this sec-
21 tion.

22 “(iii) TYPES OF INFORMATION.—The

23 types of information described in clauses
24 (i) and (ii) may, at the Secretary’s discre-
25 tion, include any or all of the following:

1 “(I) Time involved in furnishing
2 services.

3 “(II) Amounts and types of prac-
4 tice expense inputs involved with fur-
5 nishing services.

6 “(III) Prices (net of any dis-
7 counts) for practice expense inputs,
8 which may include paid invoice prices
9 or other documentation or records.

10 “(IV) Overhead and accounting
11 information for practices of physicians
12 and other suppliers.

13 “(V) Any other element that
14 would improve the valuation of serv-
15 ices under this section.

16 “(iv) INFORMATION COLLECTION
17 MECHANISMS.—Information may be col-
18 lected or obtained pursuant to this sub-
19 paragraph from any or all of the following:

20 “(I) Surveys of physicians, other
21 suppliers, providers of services, manu-
22 facturers, and vendors.

23 “(II) Surgical logs, billing sys-
24 tems, or other practice or facility
25 records.

1 “(III) Electronic health records.

2 “(IV) Any other mechanism de-
3 termined appropriate by the Sec-
4 retary.

5 “(v) TRANSPARENCY OF USE OF IN-
6 FORMATION.—

7 “(I) IN GENERAL.—Subject to
8 subclauses (II) and (III), if the Sec-
9 retary uses information collected or
10 obtained under this subparagraph in
11 the determination of relative values
12 under this subsection, the Secretary
13 shall disclose the information source
14 and discuss the use of such informa-
15 tion in such determination of relative
16 values through notice and comment
17 rulemaking.

18 “(II) THRESHOLDS FOR USE.—
19 The Secretary may establish thresh-
20 olds in order to use such information,
21 including the exclusion of information
22 collected or obtained from eligible pro-
23 fessionals who use very high resources
24 (as determined by the Secretary) in
25 furnishing a service.

1 “(III) DISCLOSURE OF INFORMA-
2 TION.—The Secretary shall make ag-
3 gregate information available under
4 this subparagraph but shall not dis-
5 close information in a form or manner
6 that identifies an eligible professional
7 or a group practice, or information
8 collected or obtained pursuant to a
9 nondisclosure agreement.

10 “(vi) INCENTIVE TO PARTICIPATE.—
11 The Secretary may provide for such pay-
12 ments under this part to an eligible profes-
13 sional that submits such solicited informa-
14 tion under this subparagraph as the Sec-
15 retary determines appropriate in order to
16 compensate such eligible professional for
17 such submission. Such payments shall be
18 provided in a form and manner specified
19 by the Secretary.

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

24 “(viii) DEFINITION OF ELIGIBLE PRO-
25 FESSIONAL.—In this subparagraph, the

1 term ‘eligible professional’ has the meaning
2 given such term in subsection (k)(3)(B).

3 “(ix) FUNDING.—For purposes of car-
4 rying out this subparagraph, in addition to
5 funds otherwise appropriated, the Sec-
6 retary shall provide for the transfer, from
7 the Federal Supplementary Medical Insur-
8 ance Trust Fund under section 1841, of
9 \$2,000,000 to the Centers for Medicare &
10 Medicaid Services Program Management
11 Account for each fiscal year beginning with
12 fiscal year 2014. Amounts transferred
13 under the preceding sentence for a fiscal
14 year shall be available until expended.”.

15 (2) LIMITATION ON REVIEW.—Section
16 1848(i)(1) of the Social Security Act (42 U.S.C.
17 1395w-4(i)(1)) is amended—

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

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

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

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

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

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

18 (c) REVISED AND EXPANDED IDENTIFICATION OF
19 POTENTIALLY MISVALUED CODES.—Section
20 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C.
21 1395w-4(c)(2)(K)(ii)) is amended to read as follows:

22 “(ii) IDENTIFICATION OF POTEN-
23 Tially MISVALUED CODES.—For purposes
24 of identifying potentially misvalued codes
25 pursuant to clause (i)(I), the Secretary

1 shall examine codes (and families of codes
2 as appropriate) based on any or all of the
3 following criteria:

4 “(I) Codes that have experienced
5 the fastest growth.

6 “(II) Codes that have experi-
7 enced substantial changes in practice
8 expenses.

9 “(III) Codes that describe new
10 technologies or services within an ap-
11 propriate time period (such as 3
12 years) after the relative values are ini-
13 tially established for such codes.

14 “(IV) Codes which are multiple
15 codes that are frequently billed in con-
16 junction with furnishing a single serv-
17 ice.

18 “(V) Codes with low relative val-
19 ues, particularly those that are often
20 billed multiple times for a single treat-
21 ment.

22 “(VI) Codes that have not been
23 subject to review since implementation
24 of the fee schedule.

1 “(VII) Codes that account for
2 the majority of spending under the
3 physician fee schedule.

4 “(VIII) Codes for services that
5 have experienced a substantial change
6 in the hospital length of stay or proce-
7 dure time.

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

11 “(X) Codes for which there is a
12 significant difference in payment for
13 the same service between different
14 sites of service.

15 “(XI) Codes for which there may
16 be anomalies in relative values within
17 a family of codes.

18 “(XII) Codes for services where
19 there may be efficiencies when a serv-
20 ice is furnished at the same time as
21 other services.

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

24 “(XIV) Codes with high practice
25 expense relative value units.

1 “(XV) Codes with high cost sup-
2 plies.

3 “(XVI) Codes as determined ap-
4 propriate by the Secretary.”.

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

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

11 “(O) TARGET FOR RELATIVE VALUE AD-
12 JUSTMENTS FOR MISVALUED SERVICES.—With
13 respect to fee schedules established for each of
14 2015 through 2018, the following shall apply:

15 “(i) DETERMINATION OF NET REDUC-
16 TION IN EXPENDITURES.—For each year,
17 the Secretary shall determine the esti-
18 mated net reduction in expenditures under
19 the fee schedule under this section with re-
20 spect to the year as a result of adjust-
21 ments to the relative values established
22 under this paragraph for misvalued codes.

23 “(ii) BUDGET NEUTRAL REDISTRIBU-
24 TION OF FUNDS IF TARGET MET AND
25 COUNTING OVERAGES TOWARDS THE TAR-

1 GET FOR THE SUCCEEDING YEAR.—If the
2 estimated net reduction in expenditures de-
3 termined under clause (i) for the year is
4 equal to or greater than the target for the
5 year—

6 “(I) reduced expenditures attrib-
7 utable to such adjustments shall be
8 redistributed for the year in a budget
9 neutral manner in accordance with
10 subparagraph (B)(ii)(II); and

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

20 “(iii) EXEMPTION FROM BUDGET
21 NEUTRALITY IF TARGET NOT MET.—If the
22 estimated net reduction in expenditures de-
23 termined under clause (i) for the year is
24 less than the target for the year, reduced
25 expenditures in an amount equal to the

1 target recapture amount shall not be taken
 2 into account in applying subparagraph
 3 (B)(ii)(II) with respect to fee schedules be-
 4 ginning with 2015.

5 “(iv) TARGET RECAPTURE AMOUNT.—
 6 For purposes of clause (iii), the target re-
 7 capture amount is, with respect to a year,
 8 an amount equal to the difference be-
 9 tween—

10 “(I) the target for the year; and

11 “(II) the estimated net reduction
 12 in expenditures determined under
 13 clause (i) for the year.

14 “(v) TARGET.—For purposes of this
 15 subparagraph, with respect to a year, the
 16 target is calculated as 0.5 percent of the
 17 estimated amount of expenditures under
 18 the fee schedule under this section for the
 19 year.”.

20 (2) CONFORMING AMENDMENT.—Section
 21 1848(c)(2)(B)(v) of the Social Security Act (42
 22 U.S.C. 1395w-4(c)(2)(B)(v)) is amended by adding
 23 at the end the following new subclause:

24 “(VIII) REDUCTIONS FOR
 25 MISVALUED SERVICES IF TARGET NOT

1 MET.—Effective for fee schedules be-
2 ginning with 2015, reduced expendi-
3 tures attributable to the application of
4 the target recapture amount described
5 in subparagraph (O)(iii).”.

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

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

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

22 (2) CONFORMING AMENDMENTS.—Section
23 1848(c)(2) of the Social Security Act (42 U.S.C.
24 1395w-4(c)(2)) is amended—

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

4 (B) in subparagraph (K)(iii)(VI)—

5 (i) by striking “provisions of subpara-
 6 graph (B)(ii)(II)” and inserting “provi-
 7 sions of subparagraph (B)(ii)(II) and para-
 8 graph (7)”; and

9 (ii) by striking “under subparagraph
 10 (B)(ii)(II)” and inserting “under subpara-
 11 graph (B)(ii)(I)”.

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

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

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

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

23 (1) STUDY.—The Comptroller General of the
 24 United States (in this subsection referred to as the
 25 “Comptroller General”) shall conduct a study of the

1 processes used by the Relative Value Scale Update
 2 Committee (RUC) to provide recommendations to
 3 the Secretary of Health and Human Services regard-
 4 ing relative values for specific services under the
 5 Medicare physician fee schedule under section 1848
 6 of the Social Security Act (42 U.S.C. 1395w-4).

7 (2) REPORT.—Not later than 1 year after the
 8 date of the enactment of this Act, the Comptroller
 9 General shall submit to Congress a report containing
 10 the results of the study conducted under paragraph
 11 (1).

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

13 (a) RECOGNIZING APPROPRIATE USE CRITERIA FOR
 14 CERTAIN IMAGING SERVICES.—

15 (1) IN GENERAL.—Section 1834 of the Social
 16 Security Act (42 U.S.C. 1395m) is amended by add-
 17 ing at the end the following new subsection:

18 “(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR
 19 CERTAIN IMAGING SERVICES.—

20 “(1) PROGRAM ESTABLISHED.—

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

1 applicable setting (as defined in subparagraph
2 (D)) by ordering professionals and furnishing
3 professionals (as defined in subparagraphs (E)
4 and (F), respectively).

5 “(B) APPROPRIATE USE CRITERIA DE-
6 FINED.—In this subsection, the term ‘appro-
7 priate use criteria’ means criteria, only devel-
8 oped or endorsed by national professional med-
9 ical specialty societies or other provider-led enti-
10 ties, to assist ordering professionals and fur-
11 nishing professionals in making the most appro-
12 priate treatment decision for a specific clinical
13 condition. To the extent feasible, such criteria
14 shall be evidence-based.

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

20 “(i) one or more applicable appro-
21 priate use criteria specified under para-
22 graph (2) apply;

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

1 “(iii) one or more of such mechanisms
2 is available free of charge.

3 “(D) APPLICABLE SETTING DEFINED.—In
4 this subsection, the term ‘applicable setting’
5 means a physician’s office, a hospital outpatient
6 department (including an emergency depart-
7 ment), an ambulatory surgical center, and any
8 other provider-led outpatient setting determined
9 appropriate by the Secretary.

10 “(E) ORDERING PROFESSIONAL DE-
11 FINED.—In this subsection, the term ‘ordering
12 professional’ means a physician (as defined in
13 section 1861(r)) or a practitioner described in
14 section 1842(b)(18)(C) who orders an applica-
15 ble imaging service for an individual.

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

22 “(2) ESTABLISHMENT OF APPLICABLE APPRO-
23 PRIATE USE CRITERIA.—

24 “(A) IN GENERAL.—Not later than No-
25 vember 15, 2015, the Secretary shall through

1 rulemaking, and in consultation with physi-
2 cians, practitioners, and other stakeholders,
3 specify applicable appropriate use criteria for
4 applicable imaging services only from among
5 appropriate use criteria developed or endorsed
6 by national professional medical specialty soci-
7 eties or other provider-led entities.

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

12 “(i) have stakeholder consensus;

13 “(ii) have been determined to be sci-
14 entifically valid and are evidence based;
15 and

16 “(iii) are based on studies that are
17 published and reviewable by stakeholders.

18 “(C) REVISIONS.—The Secretary shall pe-
19 riodically update and revise (as appropriate)
20 such specification of applicable appropriate use
21 criteria.

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

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

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

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

10 “(i) IN GENERAL.—The Secretary
11 shall specify one or more qualified clinical
12 decision support mechanisms that could be
13 used by ordering professionals to consult
14 with applicable appropriate use criteria for
15 applicable imaging services.

16 “(ii) CONSULTATION.—The Secretary
17 shall consult with physicians, practitioners,
18 and other stakeholders in specifying mech-
19 anisms under this paragraph.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 “(ii) PERIODIC UPDATING OF LIST.—
20 The Secretary shall periodically update the
21 list of qualified clinical decision support
22 mechanisms specified under this para-
23 graph.

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

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

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

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

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

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

1 consulted by the ordering professional for
2 the service.

3 “(ii) Information regarding—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 “(A) IN GENERAL.—With respect to appli-
6 cable imaging services furnished beginning with
7 2017, the Secretary shall determine, on a peri-
8 odic basis (which may be annually), ordering
9 professionals who are outlier ordering profes-
10 sionals.

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

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

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

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

1 “(D) CONSULTATION WITH STAKE-
2 HOLDERS.—The Secretary shall consult with
3 physicians, practitioners and other stakeholders
4 in developing methods to identify outlier order-
5 ing professionals under this paragraph.

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

8 “(A) IN GENERAL.—Beginning January 1,
9 2020, subject to paragraph (4)(C), with respect
10 to services furnished during a year, the Sec-
11 retary shall, for a period determined appro-
12 priate by the Secretary, apply prior authoriza-
13 tion for applicable imaging services that are or-
14 dered by an outlier ordering professional identi-
15 fied under paragraph (5).

16 “(B) FUNDING.—For purposes of carrying
17 out this paragraph, the Secretary shall provide
18 for the transfer, from the Federal Supple-
19 mentary Medical Insurance Trust Fund under
20 section 1841, of \$5,000,000 to the Centers for
21 Medicare & Medicaid Services Program Man-
22 agement Account for each of fiscal years 2019
23 through 2021. Amounts transferred under the
24 preceding sentence shall remain available until
25 expended.”.

1 (2) CONFORMING AMENDMENT.—Section
2 1833(t)(16) of the Social Security Act (42 U.S.C.
3 1395l(t)(16)) is amended by adding at the end the
4 following new subparagraph:

5 “(E) APPLICATION OF APPROPRIATE USE
6 CRITERIA FOR CERTAIN IMAGING SERVICES.—
7 For provisions relating to the application of ap-
8 propriate use criteria for certain imaging serv-
9 ices, see section 1834(p).”.

10 (b) ESTABLISHMENT OF APPROPRIATE USE PRO-
11 GRAM FOR OTHER PART B SERVICES.—Section 1834 of
12 the Social Security Act (42 U.S.C. 1395m), as amended
13 by subsection (a), is amended by adding at the end the
14 following new subsection:

15 “(q) ESTABLISHMENT OF APPROPRIATE USE PRO-
16 GRAM FOR OTHER PART B SERVICES.—

17 “(1) ESTABLISHMENT.—

18 “(A) IN GENERAL.—The Secretary may es-
19 tablish an appropriate use program for services
20 under this part (other than applicable imaging
21 services under subsection (p)) using a process
22 that is comparable to the process under such
23 subsection. With respect to appropriate use cri-
24 teria, such process shall replicate the provider-
25 developed or provider-endorsed criteria frame-

1 work for appropriate use criteria for applicable
2 imaging services under such subsection.

3 “(B) REQUIREMENTS.—In determining
4 whether to establish a program under subpara-
5 graph (A), the Secretary shall take into consid-
6 eration—

7 “(i) the applicability of the provider-
8 developed or provider-endorsed criteria
9 framework for appropriate use criteria for
10 applicable imaging services under sub-
11 section (p);

12 “(ii) the implementation of provider-
13 developed or provider-endorsed appropriate
14 use criteria for such applicable imaging
15 services; and

16 “(iii) the report under paragraph (2).

17 “(C) INPUT FROM STAKEHOLDERS IN AD-
18 VANCE OF RULEMAKING.—Before issuing a no-
19 tice of proposed rulemaking to establish a pro-
20 gram under subparagraph (A), the Secretary
21 shall issue an advance notice of proposed rule-
22 making.

23 “(2) REPORT ON EXPERIENCE OF IMAGING AP-
24 PROPRIATE USE CRITERIA PROGRAM.—Not later
25 than 18 months after the date of the enactment of

1 this subsection, the Comptroller General of the
 2 United States shall submit to Congress a report that
 3 includes a description of the extent to which appro-
 4 priate use criteria could be used for other services
 5 under this part, such as radiation therapy and clin-
 6 ical diagnostic laboratory services.”.

7 **SEC. 106. EMPOWERING BENEFICIARY CHOICES THROUGH**
 8 **ACCESS TO INFORMATION ON PHYSICIANS’**
 9 **SERVICES.**

10 (a) TRANSFERRING FREESTANDING PHYSICIAN COM-
 11 PARE PROVISION TO THE SOCIAL SECURITY ACT.—

12 (1) IN GENERAL.—Section 10331 of Public
 13 Law 111–148 is transferred and redesignated as
 14 subsection (t) of section 1848 of the Social Security
 15 Act (42 U.S.C. 1395w–4), as amended by sub-
 16 sections (c) and (h) of section 101 and by section
 17 102.

18 (2) CONFORMING REDESIGNATIONS.—Section
 19 1848(t) of the Social Security Act (42 U.S.C.
 20 1395w–4(t)), as transferred and redesignated by
 21 paragraph (1), is further amended—

22 (A) by striking the subsection heading and
 23 inserting the following new subsection heading:
 24 “PUBLIC REPORTING OF PERFORMANCE AND

1 OTHER INFORMATION ON PHYSICIAN COM-
2 PARE”;

3 (B) by redesignating subsections (a)
4 through (i) as paragraphs (1) through (9), re-
5 spectively, and indenting appropriately;

6 (C) in paragraph (1), as redesignated by
7 subparagraph (B)—

8 (i) by redesignating paragraphs (1)
9 and (2) as subparagraphs (A) and (B), re-
10 spectively, and indenting appropriately;

11 (ii) in subparagraph (B), as redesi-
12 gnated by clause (i), by redesignating sub-
13 paragraphs (A) through (G) as clauses (i)
14 through (vii), respectively, and indenting
15 appropriately;

16 (D) in paragraph (2), as redesignated by
17 subparagraph (B), by redesignating paragraphs
18 (1) through (7) as subparagraphs (A) through
19 (G), respectively, and indenting appropriately;
20 and

21 (E) in paragraph (9), as redesignated by
22 subparagraph (B), by redesignating paragraphs
23 (1) through (4) as subparagraphs (A) through
24 (D), respectively, and indenting appropriately.

1 (3) CONFORMING AMENDMENTS.—Section
2 1848(t) of the Social Security Act (42 U.S.C.
3 1395w-4(t)), as amended by paragraph (2), is fur-
4 ther amended—

5 (A) in paragraph (1)—

6 (i) in subparagraph (A)—

7 (I) by striking “the Medicare
8 program under section 1866(j) of the
9 Social Security Act (42 U.S.C.
10 1395cc(j))” and inserting “the pro-
11 gram under this title under section
12 1866(j)”; and

13 (II) by striking “of such Act (42
14 U.S.C. 1395w-4)”; and

15 (ii) in subparagraph (B), in the mat-
16 ter preceding clause (i)—

17 (I) by striking “subsection (c)”
18 and inserting “paragraph (3)”; and

19 (II) by striking “the Medicare
20 program under such section 1866(j)”
21 and inserting “the program under this
22 title under section 1866(j)”; and

23 (III) by striking “this section”
24 and inserting “this subsection”;

25 (B) in paragraph (2)—

1 (i) in the matter preceding subpara-
2 graph (A), by striking “subsection (a)(2)”
3 and inserting “paragraph (1)(B)”;

4 (ii) in subparagraph (D), by striking
5 “the Medicare program” and inserting
6 “the program under this title”; and

7 (iii) in each of subparagraphs (F) and
8 (G), by striking “this section” and insert-
9 ing “this subsection”;

10 (C) in paragraph (3), by striking “this sec-
11 tion” and inserting “this subsection”;

12 (D) in paragraph (4)—

13 (i) by striking “of the Social Security
14 Act, as added by section 3014 of this Act”;
15 and

16 (ii) by striking “this section” and in-
17 sserting “this subsection”;

18 (E) in paragraph (5)—

19 (i) by striking “this subsection (a)(2)”
20 and inserting “paragraph (1)(B)”;

21 (ii) by striking “(Public Law 110-
22 275)”;

23 (F) in paragraph (6), by striking “sub-
24 section (a)(1)” and inserting “paragraph
25 (1)(A)”;

1 (G) in paragraph (7)—

2 (i) by striking “subsection (f)” and in-
3 sserting “paragraph (6)”; and

4 (ii) by striking “title XVIII of the So-
5 cial Security Act” and inserting “this
6 title”;

7 (H) in paragraph (8)—

8 (i) by striking “subparagraphs (A)
9 through (G) of subsection (a)(2)” and in-
10 sserting “clauses (i) through (vii) of para-
11 graph (1)(B)”;

12 (ii) by striking “title XVIII of the So-
13 cial Security Act” and inserting “this
14 title”; and

15 (iii) by striking “such title” and in-
16 sserting “this title”; and

17 (I) in paragraph (9)—

18 (i) in the matter preceding subpara-
19 graph (8), by striking “this section” and
20 inserting “this subsection”;

21 (ii) in subparagraph (A), by striking
22 “of the Social Security Act (42 U.S.C.
23 1395w-4)”;

24 (iii) in subparagraph (B), by striking
25 “of such Act (42 U.S.C. 1395x(r))”;

1 (iv) in subparagraph (C), by striking
2 “subsection (a)(1)” and inserting “para-
3 graph (1)(A)”; and

4 (v) by striking subparagraph (D).

5 (b) PUBLIC AVAILABILITY OF MEDICARE DATA.—
6 Section 1848(t) of the Social Security Act (42 U.S.C.
7 1395w-4(t)), as amended by subsection (a), is further
8 amended—

9 (1) by redesignating paragraph (9) as para-
10 graph (10);

11 (2) by inserting after paragraph (8) the fol-
12 lowing new paragraph:

13 “(9) PUBLIC AVAILABILITY OF ELIGIBLE PRO-
14 FESSIONAL CLAIMS DATA.—

15 “(A) IN GENERAL.—The Secretary shall
16 make publicly available on Physician Compare
17 the information described in subparagraph (B)
18 with respect to eligible professionals.

19 “(B) INFORMATION DESCRIBED.—The fol-
20 lowing information, with respect to an eligible
21 professional, is described in this subparagraph:

22 “(i) Information on the number of
23 services furnished by the eligible profes-
24 sional, which may include information on

1 the most frequent services furnished or
2 groupings of services.

3 “(ii) Information on submitted
4 charges and payments for services under
5 this part.

6 “(iii) A unique identifier for the eligi-
7 ble professional that is available to the
8 public, such as a national provider identi-
9 fier.

10 “(C) SEARCHABILITY.—The information
11 made available under this paragraph shall be
12 searchable by at least the following:

13 “(i) The specialty or type of the eligi-
14 ble professional.

15 “(ii) Characteristics of the services
16 furnished, such as volume or groupings of
17 services.

18 “(iii) The location of the eligible pro-
19 fessional.

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

1 sional, or the health conditions of individuals
2 treated.

3 “(E) IMPLEMENTATION.—

4 “(i) INITIAL IMPLEMENTATION.—Physician Compare shall include the informa-
5 tion described in subparagraph (B)—
6

7 “(I) with respect to physicians,
8 by not later than July 1, 2015; and

9 “(II) with respect to other eligi-
10 ble professionals, by not later than
11 July 1, 2016.

12 “(ii) ANNUAL UPDATING.—The infor-
13 mation made available under this para-
14 graph shall be updated on Physician Com-
15 pare not less frequently than on an annual
16 basis.

17 “(F) OPPORTUNITY TO REVIEW AND SUB-
18 MIT CORRECTIONS.—The Secretary shall pro-
19 vide for an opportunity for an eligible profes-
20 sional to review, and submit corrections for, the
21 information to be made public with respect to
22 the eligible professional under this paragraph
23 prior to such information being made public.”;
24 and

1 (3) in paragraph (10)(C), as redesignated by
2 paragraph (1), by inserting “(or a successor
3 website)” before the period at the end.

4 **SEC. 107. EXPANDING CLAIMS DATA AVAILABILITY TO IM-**
5 **PROVE CARE.**

6 (a) **EXPANSION OF USES OF CLAIMS DATA BY**
7 **QUALIFIED ENTITIES.**—Section 1874(e) of the Social Se-
8 curity Act (42 U.S.C. 1395kk(e)) is amended by adding
9 at the end the following new paragraphs:

10 “(5) **EXPANSION OF USES OF CLAIMS DATA BY**
11 **QUALIFIED ENTITIES.**—

12 “(A) **EXPANSION.**—To the extent con-
13 sistent with applicable information, privacy, se-
14 curity, and disclosure laws, beginning July 1,
15 2014, notwithstanding paragraph (4)(B) (other
16 than clause (iii) of such paragraph) and the
17 second sentence of paragraph (4)(D), a quali-
18 fied entity may, as determined appropriate by
19 the Secretary, do any or all of the following:

20 “(i)(I) Use the combined data de-
21 scribed in paragraph (4)(B)(iii) to conduct
22 analyses, other than for reports described
23 in paragraph (4), for entities described in
24 subparagraph (B) for non-public uses, as
25 determined appropriate by the Secretary,

1 such as for the purposes described in sub-
2 clause (II).

3 “(II) The purposes described in this
4 subclause are assisting providers of serv-
5 ices and suppliers in developing and par-
6 ticipating in quality and patient care im-
7 provement activities (including developing
8 new models of care), population health
9 management, and disease monitoring, and
10 the purposes described in subparagraph
11 (C).

12 “(ii) Provide or sell such analyses to
13 entities described in subparagraph (B).

14 “(iii) Provide entities described in
15 clauses (i), (ii), (v), and (vi) of subpara-
16 graph (B) with access to the combined
17 data described in paragraph (4)(B)(iii)
18 through a qualified data enclave (as de-
19 fined in subparagraph (F)) that is main-
20 tained by the qualified entity, or through
21 an approved alternative method (as defined
22 in subparagraph (G)), in order for entities
23 described in such clauses to conduct anal-
24 yses for non-public uses, such as for the
25 purposes described in clause (i)(II) (but

1 excluding the purposes described in sub-
2 paragraph (C)).

3 “(B) ENTITIES DESCRIBED.—For the pur-
4 pose of subparagraph (A) clauses (i) and (ii),
5 the entities described in this subparagraph are
6 the following:

7 “(i) A provider of services.

8 “(ii) A supplier.

9 “(iii) Subject to subparagraph (C), an
10 employer (as defined in section 3(5) of the
11 Employee Retirement Insurance Security
12 Act of 1974).

13 “(iv) A health insurance issuer (as de-
14 fined in section 2791 of the Public Health
15 Service Act) that provides data under
16 paragraph (4)(B)(iii).

17 “(v) A medical society or hospital as-
18 sociation.

19 “(vi) Other entities approved by the
20 Secretary (other than an employer (as so
21 defined) and a health insurance issuer (as
22 so defined)).

23 “(C) LIMITATION FOR EMPLOYERS WITH
24 RESPECT TO ANALYSES.—Any analyses pro-
25 vided or sold under this paragraph to an em-

1 ployer (as so defined) may only be used by such
2 employer for purposes of providing health insur-
3 ance to employees and retirees of the employer.

4 “(D) PROTECTION OF PATIENT IDENTI-
5 FICATION IN ANALYSES.—

6 “(i) IN GENERAL.—Except as pro-
7 vided in clause (ii), an analysis provided or
8 sold under this paragraph shall not contain
9 information that individually identifies a
10 patient.

11 “(ii) INFORMATION ON PATIENTS OF
12 THE PROVIDER OF SERVICES OR SUP-
13 PLIER.—An analysis that is provided or
14 sold under this paragraph to a provider of
15 services or supplier may contain data that
16 individually identifies a patient of such
17 provider or supplier but only with respect
18 to items and services furnished by such
19 provider or supplier to such patient.

20 “(iii) OPPORTUNITY FOR PROVIDERS
21 OF SERVICES AND SUPPLIERS TO RE-
22 VIEW.—Prior to a qualified entity pro-
23 viding or selling an analysis under this
24 paragraph to an entity described in sub-
25 paragraph (B), to the extent that such

1 analysis would individually identify a pro-
2 vider of services or supplier who is not
3 being provided or sold such analysis, such
4 qualified entity shall provide an oppor-
5 tunity for such provider or supplier to re-
6 view and submit corrections to such anal-
7 ysis.

8 “(E) NO REDISCLOSURE OF ANALYSES OR
9 DATA.—An entity described in subparagraph
10 (B) that is provided or sold analyses under this
11 paragraph, or an entity described in subpara-
12 graph (A)(iii) that receives data under this
13 paragraph through a qualified data enclave or
14 an approved alternative method, shall not redis-
15 close or make public such analyses, such data,
16 or analyses using such data.

17 “(F) REQUIREMENTS FOR A QUALIFIED
18 DATA ENCLAVE.—

19 “(i) DEFINITION.—For purposes of
20 this paragraph, the term ‘qualified data
21 enclave’ means a data enclave that the
22 Secretary determines meets the following:

23 “(I) The data enclave is a virtual
24 private network or comparable mecha-
25 nism.

1 “(II) Subject to the requirements
2 described in clause (ii) and such other
3 requirements as the Secretary may
4 specify, the data enclave is capable of
5 providing access to the combined data
6 described in subparagraph (A)(iii).

7 “(ii) ENCLAVE ACCESS REQUIRE-
8 MENTS.—The requirements described in
9 this clause are the following:

10 “(I) A qualified data enclave
11 shall preclude any entity that obtains
12 access to the data from removing or
13 extracting the data from such enclave.

14 “(II) Subject to the succeeding
15 sentence, the enclave shall preclude
16 access to data that individually identi-
17 fies a patient, including data on the
18 patient’s name and date of birth and
19 such other data as the Secretary shall
20 specify. Such data enclave may pro-
21 vide providers of services and sup-
22 pliers with access to such individually
23 identifiable patient data but only with
24 respect to items and services fur-

1 nished by such provider or supplier to
2 such patient.

3 “(III) Access to data in the en-
4 clave shall not be provided to any en-
5 tity unless the qualified entity and the
6 entity have entered into a data use
7 agreement, the terms of which contain
8 the requirements of this paragraph
9 and paragraph (6) and such other
10 terms the Secretary may specify.

11 “(G) APPROVED ALTERNATIVE METHOD.—
12 For purposes of this paragraph, the term ‘ap-
13 proved alternative method’ means a method of
14 providing access to the data described in sub-
15 paragraph (A)(iii) (other than through a quali-
16 fied data enclave) to entities described in such
17 paragraph that the Secretary determines meets
18 the following:

19 “(i) The method is as secure as a
20 qualified data enclave.

21 “(ii) The method meets the require-
22 ments applicable to a qualified data en-
23 clave under subclauses (II) and (III) of
24 subparagraph (F)(ii).

1 “(iii) The method meets other require-
2 ments determined appropriate by the Sec-
3 retary.

4 “(H) ANNUAL REPORTS.—Any qualified
5 entity that provides or sells analyses pursuant
6 to subparagraph (A)(ii), or provides access to a
7 data through an approved data enclave or an
8 approved alternative method, shall annually
9 submit to the Secretary a report that in-
10 cludes—

11 “(i) a summary of the analyses pro-
12 vided or sold, including the number of such
13 analyses, the number of purchasers of such
14 analyses, and the total amount of fees re-
15 ceived for such analyses;

16 “(ii) a description of the topics and
17 purposes of such analyses;

18 “(iii) information on the entities who
19 obtained access to data pursuant to sub-
20 paragraph (A)(iii), the uses of the data,
21 and the total amount of fees received for
22 providing such access; and

23 “(iv) other information determined
24 appropriate by the Secretary.

1 “(6) CIVIL MONETARY PENALTIES FOR A
2 BREACH OF A DATA USE AGREEMENT.—A data use
3 agreement under this subsection shall provide for
4 civil monetary penalties (as determined appropriate
5 by the Secretary) for a breach of such agreement.”.

6 (b) EXPANSION OF DATA AVAILABLE TO QUALIFIED
7 ENTITIES.—Section 1874(e) of the Social Security Act
8 (42 U.S.C. 1395kk(e)) is amended—

9 (1) in the subsection heading, by striking
10 “Medicare”; and

11 (2) in paragraph (3)—

12 (A) by inserting after the first sentence the
13 following new sentence: “Effective July 1,
14 2014, if the Secretary determines appropriate,
15 the data described in this paragraph may also
16 include standardized extracts (as determined by
17 the Secretary) of claims data under titles XIX
18 and XXI for assistance provided under such ti-
19 tles for one or more specified geographic areas
20 and time periods requested by a qualified enti-
21 ty.”; and

22 (B) in the last sentence, by inserting “or
23 under titles XIX or XXI” before the period at
24 the end.

1 (c) ACCESS TO MEDICARE DATA BY QUALIFIED
2 CLINICAL DATA REGISTRIES TO FACILITATE QUALITY
3 IMPROVEMENT.—Section 1848(m)(3)(E) of the Social Se-
4 curity Act (42 U.S.C. 1395w-4(m)(3)(E)) is amended by
5 adding at the end the following new clause:

6 “(vi) ACCESS TO MEDICARE DATA TO
7 FACILITATE QUALITY IMPROVEMENT.—

8 “(I) IN GENERAL.—To the extent
9 consistent with applicable information,
10 privacy, security, and disclosure laws,
11 and subject to other requirements as
12 the Secretary may specify, beginning
13 July 1, 2014, the Secretary shall, if
14 requested by a qualified clinical data
15 registry under this subparagraph, sub-
16 ject to subclauses (II) and (III), pro-
17 vide data as described in section
18 1874(e)(3) (in a form and manner de-
19 termined to be appropriate) to such
20 registry for purposes of linking such
21 data with clinical data and performing
22 analyses and research to support qual-
23 ity improvement or patient safety.

24 “(II) PROTECTION.—A qualified
25 clinical data registry may not publicly

1 report any data made available under
2 subclause (I) (or any analyses or re-
3 search described in such subclause)
4 that individually identifies a provider
5 of services, supplier, or individual un-
6 less the registry obtains the consent of
7 such provider, supplier, or individual
8 prior to such reporting.

9 “(III) FEE.—The data described
10 in subclause (I) shall be made avail-
11 able to qualified clinical data reg-
12 istries at a fee equal to the cost of
13 making such data available. Any fee
14 collected pursuant to the preceding
15 sentence shall be deposited in the
16 Centers for Medicare & Medicaid
17 Services Program Management Ac-
18 count.”.

19 (d) REVISION OF PLACEMENT OF FEES.—Section
20 1874(e)(4)(A) of the Social Security Act (42 U.S.C.
21 1395kk(e)(4)(A)) is amended, in the second sentence—

22 (1) by inserting “, for periods prior to July 1,
23 2014,” after “deposited”; and

24 (2) by inserting the following before the period
25 at the end: “, and, beginning July 1, 2014, into the

1 Centers for Medicare & Medicaid Services Program
2 Management Account”.

3 **TITLE II—EXTENSIONS AND**
4 **OTHER PROVISIONS**

5 **Subtitle A—Medicare Extensions**

6 **SEC. 201. WORK GEOGRAPHIC ADJUSTMENT.**

7 Section 1848(e)(1)(E) of the Social Security Act (42
8 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “and
9 before January 1, 2014,”.

10 **SEC. 202. MEDICARE PAYMENT FOR THERAPY SERVICES.**

11 (a) REPEAL OF THERAPY CAP AND 1-YEAR EXTEN-
12 SION OF THRESHOLD FOR MANUAL MEDICAL REVIEW.—
13 Section 1833(g) of the Social Security Act (42 U.S.C.
14 1395l(g)) is amended—

15 (1) in paragraph (4)—

16 (A) by striking “This subsection” and in-
17 serting “Except as provided in paragraph
18 (5)(C), this subsection”; and

19 (B) by inserting the following before the
20 period at the end: “or with respect to services
21 furnished on or after the date of enactment of
22 the SGR Repeal and Medicare Beneficiary Ac-
23 cess Act of 2013”.

24 (2) in paragraph (5)(C)—

1 (A) in clause (i), by inserting “and before
2 January 1, 2015,” after “2012,”; and

3 (B) by adding at the end the following new
4 clause:

5 “(iii) With respect to services furnished during the
6 period beginning on the date of enactment of the SGR
7 Repeal and Medicare Beneficiary Access Act of 2013, and
8 ending on December 31, 2014, the provisions of this para-
9 graph shall only apply to the extent necessary to carry
10 out the manual medical review process under this subpara-
11 graph.”.

12 (b) MEDICAL REVIEW OF OUTPATIENT THERAPY
13 SERVICES.—

14 (1) MEDICAL REVIEW OF OUTPATIENT THER-
15 APY SERVICES.—Section 1833 of the Social Security
16 Act (42 U.S.C. 1395l), as amended by section
17 101(e), is amended by adding at the end the fol-
18 lowing new subsection:

19 “(aa) MEDICAL REVIEW OF OUTPATIENT THERAPY
20 SERVICES.—

21 “(1) IN GENERAL.—

22 “(A) PROCESS FOR MEDICAL REVIEW.—

23 The Secretary shall implement a process for the
24 medical review (as described in paragraph (2))
25 of outpatient therapy services (as defined in

1 paragraph (10)) and, subject to paragraph
2 (12), apply such process to such services fur-
3 nished on or after January 1, 2015, focusing on
4 services identified under subparagraph (B).

5 “(B) IDENTIFICATION OF SERVICES FOR
6 REVIEW.—Under the process, the Secretary
7 shall identify services for medical review, using
8 such factors as the Secretary determines appro-
9 priate, which may include the following:

10 “(i) Services furnished by a therapy
11 provider (as defined in paragraph (10))
12 whose pattern of billing is higher compared
13 to peers.

14 “(ii) Services furnished by a therapy
15 provider who, in a prior period, has a high
16 claims denial percentage or is least compli-
17 ant with other applicable requirements
18 under this title.

19 “(iii) Services furnished by a therapy
20 provider that is newly enrolled under this
21 title.

22 “(iv) Services furnished by a therapy
23 provider who has questionable billing prac-
24 tices, such as billing medically unlikely
25 units of services in a day.

1 “(v) Services furnished to treat a type
2 of medical condition.

3 “(vi) Services identified by use of the
4 standardized data elements required to be
5 reported under section 1834(p).

6 “(vii) Services furnished by a single
7 therapy provider or a group that includes
8 a therapy provider identified by factors de-
9 scribed in this subparagraph.

10 “(viii) Other services as determined
11 appropriate by the Secretary.

12 “(2) MEDICAL REVIEW.—

13 “(A) PRIOR AUTHORIZATION MEDICAL RE-
14 VIEW.—

15 “(i) IN GENERAL.—Subject to the
16 succeeding provisions of this subparagraph,
17 the Secretary shall use prior authorization
18 medical review for outpatient therapy serv-
19 ices furnished to an individual above one
20 or more thresholds established by the Sec-
21 retary, such as a dollar threshold or a
22 threshold based on factors such as the type
23 of outpatient therapy service or setting.

24 “(ii) ENDING APPLICATION OF PRIOR
25 AUTHORIZATION FOR A THERAPY PRO-

1 VIDER.—The Secretary shall end the appli-
2 cation of prior authorization medical re-
3 view to outpatient therapy services fur-
4 nished by a therapy provider if the Sec-
5 retary determines that the provider has a
6 low denial rate under such prior authoriza-
7 tion. The Secretary may subsequently re-
8 apply prior authorization medical review to
9 such therapy provider if the Secretary de-
10 termines it to be appropriate.

11 “(iii) PRIOR AUTHORIZATION OF MUL-
12 TIPLE SERVICES.—The Secretary shall,
13 where practicable, provide for prior author-
14 ization medical review for multiple services
15 at a single time, such as services in a ther-
16 apy plan of care described in section
17 1861(p)(2).

18 “(B) OTHER TYPES OF MEDICAL RE-
19 VIEW.—The Secretary may use pre-payment re-
20 view or post-payment review for services identi-
21 fied under paragraph (1)(B) that are not sub-
22 ject to prior authorization medical review under
23 subparagraph (A).

24 “(C) LIMITATION FOR LAW ENFORCEMENT
25 ACTIVITIES.—The Secretary may determine

1 that medical review under this subsection does
2 not apply in the case where fraud may be in-
3 volved.

4 “(3) REVIEW CONTRACTORS.—The Secretary
5 shall conduct prior authorization medical review of
6 outpatient therapy services under this subsection
7 using medicare administrative contractors (as de-
8 scribed in section 1874A) or other review contrac-
9 tors (other than contractors under section 1893(h)
10 or contractors paid on a contingent basis).

11 “(4) NO PAYMENT WITHOUT PRIOR AUTHORIZA-
12 TION.—With respect to an outpatient therapy service
13 for which prior authorization medical review under
14 this subsection applies, no payment shall be made
15 under this part for the service unless a prior author-
16 ization determination is made, in advance of fur-
17 nishing such service, that such service would meet
18 the applicable requirements of section
19 1862(a)(1)(A).

20 “(5) SUBMISSION OF INFORMATION.—A ther-
21 apy provider may submit the information necessary
22 for medical review by fax, by mail, or by electronic
23 means. The Secretary shall make available the elec-
24 tronic means described in the preceding sentence as

1 soon as practicable, but not later than 24 months
2 after the date of enactment of this subsection.

3 “(6) TIMELINESS.—The Secretary shall make a
4 prior authorization determination under this sub-
5 section within 10 business days of the date of the
6 Secretary’s receipt of medical documentation needed
7 to make such determination or the Secretary shall
8 be deemed to have found the services to meet the ap-
9 plicable requirements of section 1862(a)(1)(A).

10 “(7) CONSTRUCTION.—With respect to an out-
11 patient therapy service that has been affirmed by
12 medical review under this subsection, nothing in this
13 subsection shall be construed to preclude the subse-
14 quent denial of a claim for such service that does
15 not meet other applicable requirements under this
16 Act.

17 “(8) BENEFICIARY PROTECTIONS.—With re-
18 spect to services furnished on or after January 1,
19 2015, where payment may not be made as a result
20 of application of medical review under this sub-
21 section, section 1879 shall apply in the same manner
22 as such section applies to a denial that is made by
23 reason of section 1862(a)(1).

24 “(9) IMPLEMENTATION.—

1 “(A) AUTHORITY.—The Secretary may im-
2 plement the provisions of this subsection by in-
3 terim final rule with comment period.

4 “(B) ADMINISTRATION.—Chapter 35 of
5 title 44, United States Code, shall not apply to
6 medical review under this subsection.

7 “(10) DEFINITIONS.—For purposes of this sub-
8 section:

9 “(A) OUTPATIENT THERAPY SERVICES.—
10 The term ‘outpatient therapy services’ means
11 the following services for which payment is
12 made under section 1848, 1834(g), or 1834(k):

13 “(i) Physical therapy services of the
14 type described in section 1861(p).

15 “(ii) Speech-language pathology serv-
16 ices of the type described in such section
17 though the application of section
18 1861(ll)(2).

19 “(iii) Occupational therapy services of
20 the type described in section 1861(p)
21 through the operation of section 1861(g).

22 “(B) THERAPY PROVIDER.—The term
23 ‘therapy provider’ means a provider of services
24 (as defined in section 1861(u)) or a supplier (as

1 defined in section 1861(d)) who submits a claim
2 for outpatient therapy services.

3 “(11) FUNDING.—For purposes of imple-
4 menting this subsection, the Secretary shall provide
5 for the transfer, from the Federal Supplementary
6 Medical Insurance Trust Fund under section 1841,
7 of \$35,000,000 to the Centers for Medicare & Med-
8 icaid Services Program Management Account for
9 each fiscal year (beginning with fiscal year 2014).
10 Amounts transferred under this paragraph shall re-
11 main available until expended.

12 “(12) SCALING BACK.—

13 “(A) PERIODIC DETERMINATIONS.—Begin-
14 ning with 2017, and every two years thereafter,
15 the Secretary shall—

16 “(i) make a determination of the im-
17 proper payment rate for outpatient therapy
18 services for a 12-month period; and

19 “(ii) make such determination publicly
20 available.

21 “(B) SCALING BACK.—If the improper
22 payment rate for outpatient therapy services de-
23 termined for a 12-month period under subpara-
24 graph (A) is 50 percent or less of the Medicare

1 fee-for-service improper payment rate for such
2 period, the Secretary shall—

3 “(i) reduce the amount and extent of
4 medical review conducted for a prospective
5 year under the process established in this
6 subsection; and

7 “(ii) return an appropriate portion of
8 the funding provided for such year under
9 paragraph (11).”.

10 (2) GAO STUDY AND REPORT.—

11 (A) STUDY.—The Comptroller General of
12 the United States shall conduct a study on the
13 effectiveness of medical review of outpatient
14 therapy services under section 1833(aa) of the
15 Social Security Act, as added by paragraph (2).

16 Such study shall include an analysis of—

17 (i) aggregate data on—

18 (I) the number of individuals,
19 therapy providers, and claims subject
20 to such review; and

21 (II) the number of reviews con-
22 ducted under such section; and

23 (ii) the outcomes of such reviews.

24 (B) REPORT.—Not later than 3 years after
25 the date of enactment of this Act, the Comp-

1 troller General shall submit to Congress a re-
2 port containing the results of the study under
3 subparagraph (A), together with recommenda-
4 tions for such legislation and administrative ac-
5 tion as the Comptroller General determines ap-
6 propriate.

7 (c) COLLECTION OF STANDARDIZED DATA ELE-
8 MENTS FOR OUTPATIENT THERAPY SERVICES.—

9 (1) COLLECTION OF STANDARDIZED DATA ELE-
10 MENTS FOR OUTPATIENT THERAPY SERVICES.—Sec-
11 tion 1834 of the Social Security Act (42 U.S.C.
12 1395m) is amended by adding at the end the fol-
13 lowing new subsection:

14 “(p) COLLECTION OF STANDARDIZED DATA ELE-
15 MENTS FOR OUTPATIENT THERAPY SERVICES.—

16 “(1) STANDARDIZED DATA ELEMENTS.—

17 “(A) IN GENERAL.—Not later than 6
18 months after the date of enactment of this sub-
19 section, the Secretary shall post on the Internet
20 website of the Centers for Medicare & Medicaid
21 Services a draft list of standardized data ele-
22 ments for individuals receiving outpatient ther-
23 apy services.

24 “(B) DOMAINS.—Such standardized data
25 elements shall include information with respect

1 to the following domains, as determined appro-
2 priate by the Secretary:

3 “(i) Demographic information.

4 “(ii) Diagnosis.

5 “(iii) Severity.

6 “(iv) Affected body structures and
7 functions.

8 “(v) Limitations with activities of
9 daily living and participation.

10 “(vi) Functional status.

11 “(vii) Other domains determined to be
12 appropriate by the Secretary.

13 “(C) SOLICITATION OF INPUT.—The Sec-
14 retary shall accept comments from stakeholders
15 through the date that is 60 days after the date
16 the Secretary posts the draft list of standard-
17 ized data elements pursuant to subparagraph
18 (A). In seeking such comments, the Secretary
19 shall use one or more mechanisms to solicit
20 input from stakeholders that may include use of
21 open door forums, town hall meetings, requests
22 for information, or other mechanisms deter-
23 mined appropriate by the Secretary.

24 “(D) OPERATIONAL LIST OF STANDARD-
25 IZED DATA ELEMENTS.—Not later than 120

1 days after the end of the comment period de-
2 scribed in subparagraph (C), the Secretary, tak-
3 ing into account such comments, shall post on
4 the Internet website of the Centers for Medi-
5 care & Medicaid Services an operational list of
6 standardized data elements.

7 “(E) SUBSEQUENT REVISIONS.—Subse-
8 quent revisions to the operational list of stand-
9 arized data elements shall be made through
10 rulemaking. Such revisions may be based on ex-
11 perience and input from stakeholders.

12 “(2) SYSTEM TO REPORT STANDARDIZED DATA
13 ELEMENTS.—

14 “(A) IN GENERAL.—Not later than 18
15 months after the date the Secretary posts the
16 operational list of standardized data elements
17 pursuant to paragraph (1)(D), the Secretary
18 shall develop and implement an electronic sys-
19 tem (which may be a web portal) for therapy
20 providers to report the standardized data ele-
21 ments for individuals with respect to outpatient
22 therapy services.

23 “(B) CONSULTATION.—The Secretary
24 shall seek comments from stakeholders regard-

1 ing the best way to report the standardized
2 data elements.

3 “(3) REPORTING.—

4 “(A) FREQUENCY OF REPORTING.—The
5 Secretary shall specify the frequency of report-
6 ing standardized data elements. The Secretary
7 shall seek comments from stakeholders regard-
8 ing the frequency of the reporting of such data
9 elements.

10 “(B) REPORTING REQUIREMENT.—Begin-
11 ning on the date the system to report standard-
12 ized data elements under this subsection is
13 operational, no payment shall be made under
14 this part for outpatient therapy services fur-
15 nished to an individual unless a therapy pro-
16 vider reports the standardized data elements for
17 such individual.

18 “(4) REPORT ON NEW PAYMENT SYSTEM FOR
19 OUTPATIENT THERAPY SERVICES.—

20 “(A) IN GENERAL.—Not later than 18
21 months after the date described in paragraph
22 (3)(B), the Secretary shall submit to Congress
23 a report on the design of a new payment system
24 for outpatient therapy services. The report shall
25 include an analysis of the standardized data ele-

1 ments collected and other appropriate data and
2 information.

3 “(B) FEATURES.—Such report shall con-
4 sider—

5 “(i) appropriate adjustments to pay-
6 ment (such as case mix and outliers);

7 “(ii) payments on an episode of care
8 basis; and

9 “(iii) reduced payment for multiple
10 episodes.

11 “(C) CONSULTATION.—The Secretary shall
12 consult with stakeholders regarding the design
13 of such a new payment system.

14 “(5) IMPLEMENTATION.—

15 “(A) FUNDING.—For purposes of imple-
16 menting this subsection, the Secretary shall
17 provide for the transfer, from the Federal Sup-
18 plementary Medical Insurance Trust Fund
19 under section 1841, of \$7,000,000 to the Cen-
20 ters for Medicare & Medicaid Services Program
21 Management Account for each of fiscal years
22 2014 through 2018. Amounts transferred under
23 this subparagraph shall remain available until
24 expended.

1 “(B) ADMINISTRATION.—Chapter 35 of
2 title 44, United States Code, shall not apply to
3 specification of the standardized data elements
4 and implementation of the system to report
5 such standardized data elements under this
6 subsection.

7 “(C) LIMITATION.—There shall be no ad-
8 ministrative or judicial review under section
9 1869, section 1878, or otherwise of the speci-
10 fication of standardized data elements required
11 under this subsection or the system to report
12 such standardized data elements.

13 “(D) DEFINITION OF OUTPATIENT THER-
14 APY SERVICES AND THERAPY PROVIDER.—In
15 this subsection, the terms ‘outpatient therapy
16 services’ and ‘therapy provider’ have the mean-
17 ing given those term in section 1833(aa).”.

18 (2) SUNSET OF CURRENT CLAIMS-BASED COL-
19 LECTION OF THERAPY DATA.—Section 3005(g)(1) of
20 the Middle Class Tax Extension and Job Creation
21 Act of 2012 (42 U.S.C. 1395l note) is amended, in
22 the first sentence, by inserting “and ending on the
23 date the system to report standardized data ele-
24 ments under section 1834(p) of the Social Security

1 Act (42 U.S.C. 1395m(p)) is implemented,” after
2 “January 1, 2013,”.

3 (d) REPORTING OF CERTAIN INFORMATION.—Sec-
4 tion 1842(t) of the Social Security Act (42 U.S.C.
5 1395u(t)) is amended by adding at the end the following
6 new paragraph:

7 “(3) Each request for payment, or bill submitted, by
8 a therapy provider (as defined in section 1833(aa)(10))
9 for an outpatient therapy service (as defined in such sec-
10 tion) furnished by a therapy assistant on or after January
11 1, 2015, shall include (in a form and manner specified
12 by the Secretary) an indication that the service was fur-
13 nished by a therapy assistant.”.

14 **SEC. 203. MEDICARE AMBULANCE SERVICES.**

15 (a) EXTENSION OF CERTAIN AMBULANCE ADD-ON
16 PAYMENTS.—

17 (1) GROUND AMBULANCE.—Section
18 1834(l)(13)(A) of the Social Security Act (42 U.S.C.
19 1395m(l)(13)(A)) is amended by striking “January
20 1, 2014” and inserting “January 1, 2019” each
21 place it appears.

22 (2) SUPER RURAL AMBULANCE.—Section
23 1834(l)(12)(A) of the Social Security Act (42 U.S.C.
24 1395m(l)(12)(A)) is amended, in the first sentence,

1 by striking “January 1, 2014” and inserting “Janu-
2 ary 1, 2019”.

3 (b) REQUIRING AMBULANCE PROVIDERS TO SUBMIT
4 COST AND OTHER INFORMATION.—Section 1834(l) of the
5 Social Security Act (42 U.S.C. 1395m(l)) is amended by
6 adding at the end the following new paragraph:

7 “(16) SUBMISSION OF COST AND OTHER INFOR-
8 MATION.—

9 “(A) DEVELOPMENT OF DATA COLLECTION
10 SYSTEM.—The Secretary shall develop a data
11 collection system (which may include use of a
12 cost survey and standardized definitions) for
13 providers and suppliers of ambulance services to
14 collect cost, revenue, utilization, and other in-
15 formation determined appropriate by the Sec-
16 retary. Such system shall be designed to submit
17 information—

18 “(i) needed to evaluate the appro-
19 priateness of payment rates under this
20 subsection;

21 “(ii) on the utilization of capital
22 equipment and ambulance capacity; and

23 “(iii) on different types of ambulance
24 services furnished in different geographic
25 locations, including rural areas and low

1 population density areas described in para-
2 graph (12).

3 “(B) SPECIFICATION OF DATA COLLEC-
4 TION SYSTEM.—

5 “(i) IN GENERAL.—Not later than
6 January 1, 2015, the Secretary shall—

7 “(I) specify the data collection
8 system under subparagraph (A); and

9 “(II) identify the providers and
10 suppliers of ambulance services who
11 would be required to submit the infor-
12 mation under such data collection sys-
13 tem.

14 “(ii) RESPONDENTS.—Subject to sub-
15 paragraph (D)(ii), the Secretary shall de-
16 termine an appropriate sample of providers
17 and suppliers of ambulance services to sub-
18 mit information under the data collection
19 system each year.

20 “(C) REPORTING OF COST INFORMA-
21 TION.—Beginning July 1, 2015, a 5 percent re-
22 duction to payments under this part shall be
23 made for a 1-year period to a provider or sup-
24 plier of ambulance services who—

1 “(i) is identified under subparagraph
2 (B)(i)(II) as being required to submit the
3 information under the data collection sys-
4 tem; and

5 “(ii) does not submit such informa-
6 tion.

7 “(D) ONGOING DATA COLLECTION.—

8 “(i) REVISION OF DATA COLLECTION
9 SYSTEM.—The Secretary may revise, as
10 the Secretary determines appropriate, the
11 data collection system. The Secretary shall
12 consult with providers and suppliers of am-
13 bulance services when revising such sys-
14 tem.

15 “(ii) SUBSEQUENT DATA COLLEC-
16 TION.—In order to continue to evaluate
17 the appropriateness of payment rates
18 under this subsection, the Secretary shall
19 require providers and suppliers of ambu-
20 lance services to submit information for
21 years after 2015 as the Secretary deter-
22 mines appropriate, but in no case less
23 often than once every 3 years.

24 “(E) CONSULTATION.—The Secretary shall
25 consult with stakeholders in carrying out the

1 development of the system and collection of in-
2 formation under this paragraph, including the
3 activities described in subparagraphs (A) and
4 (D). Such consultation shall include the use of
5 requests for information and other mechanisms
6 determined appropriate by the Secretary.

7 “(F) ADMINISTRATION.—Chapter 35 of
8 title 44, United States Code, shall not apply to
9 the collection of information required under this
10 subsection.

11 “(G) LIMITATIONS ON REVIEW.—There
12 shall be no administrative or judicial review
13 under section 1869, section 1878, or otherwise
14 of the data collection system or identification of
15 respondents under this paragraph.

16 “(H) FUNDING FOR IMPLEMENTATION.—
17 For purposes of carrying out subparagraph (A),
18 the Secretary shall provide for the transfer,
19 from the Federal Supplementary Medical Insur-
20 ance Trust Fund under section 1841, of
21 \$1,000,000 to the Centers for Medicare & Med-
22 icaid Services Program Management Account
23 for fiscal year 2014. Amounts transferred under
24 this subparagraph shall remain available until
25 expended.”.

1 **SEC. 204. REVISION OF THE MEDICARE-DEPENDENT HOS-**
2 **PITAL (MDH) PROGRAM.**

3 (a) PERMANENT EXTENSION OF PAYMENT METHOD-
4 OLOGY.—

5 (1) IN GENERAL.—Section 1886(d)(5)(G) of
6 the Social Security Act (42 U.S.C.
7 1395ww(d)(5)(G)) is amended—

8 (A) in clause (i), by striking “and before
9 October 1, 2013,”; and

10 (B) in clause (ii)(II), by striking “and be-
11 fore October 1, 2013,”.

12 (2) CONFORMING AMENDMENTS.—

13 (A) TARGET AMOUNT.—Section
14 1886(b)(3)(D) of the Social Security Act (42
15 U.S.C. 1395ww(b)(3)(D)) is amended—

16 (i) in the matter preceding clause (i),
17 by striking “and before October 1, 2013,”;
18 and

19 (ii) in clause (iv), by striking
20 “through fiscal year 2013” and inserting
21 “or a subsequent fiscal year”.

22 (B) HOSPITAL VALUE-BASED PURCHASING
23 PROGRAM.—Section 1886(o)(7)(D)(ii)(I) of the
24 Social Security Act (42 U.S.C.
25 1395ww(o)(7)(D)(ii)(I)) is amended by striking

1 “(with respect to discharges occurring during
2 fiscal year 2012 and 2013)”.

3 (C) HOSPITAL READMISSION REDUCTION
4 PROGRAM.—Section 1886(q)(2)(B)(i) of the So-
5 cial Security Act (42 U.S.C.
6 1395ww(q)(2)(B)(i)) is amended by striking
7 “(with respect to discharges occurring during
8 fiscal years 2012 and 2013)”.

9 (D) PERMITTING HOSPITALS TO DECLINE
10 RECLASSIFICATION.—Section 13501(e)(2) of
11 the Omnibus Budget Reconciliation Act of 1993
12 (42 U.S.C. 1395ww note) is amended by strik-
13 ing “fiscal year 1998, fiscal year 1999, or fiscal
14 year 2000 through fiscal year 2013” and insert-
15 ing “or fiscal year 1998 or a subsequent fiscal
16 year”.

17 (b) GAO STUDY AND REPORT ON MEDICARE-DE-
18 PENDENT HOSPITALS.—

19 (1) STUDY.—The Comptroller General of the
20 United States shall conduct a study on the following:

21 (A) The payor mix of medicare-dependent,
22 small rural hospitals (as defined in section
23 1886(d)(5)(G)(iv)), how such mix will trend in
24 future years, and whether or not the require-

1 ment under subclause (IV) of such section
2 should be revised.

3 (B) The characteristics of medicare-de-
4 pendent, small rural hospitals that meet the re-
5 quirement of such subclause (IV) through the
6 application of paragraph (a)(iii)(A) or
7 (a)(iii)(B) of section 412.108 of the Code of
8 Federal Regulations, including Medicare inpa-
9 tient and outpatient utilization, payor mix, and
10 financial status, including Medicare and total
11 margins, and whether or not Medicare pay-
12 ments for such hospitals should be revised.

13 (C) Such other items related to medicare-
14 dependent, small rural hospitals as the Comp-
15 troller General determines appropriate.

16 (2) REPORT.—Not later than 12 months after
17 the date of the enactment of this Act, the Comp-
18 troller General of the United States shall submit to
19 Congress a report on the study conducted under
20 paragraph (1), together with recommendations for
21 such legislation and administrative action as the
22 Comptroller General determines appropriate.

23 (c) IMPLEMENTATION.—Notwithstanding any other
24 provision of law, the Secretary of Health and Human
25 Services may implement the provisions of, and the amend-

1 ments made by, this section through program instruction
2 or otherwise.

3 **SEC. 205. REVISION OF MEDICARE INPATIENT HOSPITAL**
4 **PAYMENT ADJUSTMENT FOR LOW-VOLUME**
5 **HOSPITALS.**

6 (a) IN GENERAL.—Section 1886(d)(12) of the Social
7 Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

8 (1) in subparagraph (B)—

9 (A) in the subparagraph heading, by in-
10 sserting “FOR FISCAL YEARS 2005 THROUGH
11 2010” after “INCREASE”; and

12 (B) in the matter preceding clause (i), by
13 striking “and for discharges occurring in fiscal
14 year 2014 and subsequent years”;

15 (2) in subparagraph (C)(i), by striking “fiscal
16 years 2011, 2012, and 2013” and inserting “fiscal
17 year 2011 and subsequent fiscal years” each place
18 it appears; and

19 (3) in subparagraph (D)—

20 (A) in the heading, by striking “TEM-
21 PORARY APPLICABLE PERCENTAGE INCREASE”
22 and inserting “APPLICABLE PERCENTAGE IN-
23 CREASE FOR FISCAL YEAR 2011 AND SUBSE-
24 QUENT FISCAL YEARS”; and

1 (B) by striking “fiscal years 2011, 2012,
2 and 2013” and inserting “fiscal year 2011 or
3 a subsequent fiscal year”;

4 (b) IMPLEMENTATION.—Notwithstanding any other
5 provision of law, the Secretary of Health and Human
6 Services may implement the provisions of, and the amend-
7 ments made by, this section through program instruction
8 or otherwise.

9 **SEC. 206. SPECIALIZED MEDICARE ADVANTAGE PLANS FOR**
10 **SPECIAL NEEDS INDIVIDUALS.**

11 (a) EXTENSION.—Section 1859(f)(1) of the Social
12 Security Act (42 U.S.C. 1395w-28(f)(1)) is amended—

13 (1) by striking “ENROLLMENT.—In the case”
14 and inserting “ENROLLMENT.—

15 “(A) IN GENERAL.—Subject to subpara-
16 graphs (B) and (C), in the case”;

17 (2) in subparagraph (A), as added by para-
18 graph (1), by striking “and for periods before Janu-
19 ary 1, 2015”; and

20 (3) by adding at the end the following new sub-
21 paragraphs:

22 “(B) APPLICATION TO DUAL SNPS.—Sub-
23 paragraph (A) shall only apply to a specialized
24 MA plan for special needs individuals described

1 in subsection (b)(6)(B)(ii) for periods before
2 January 1, 2021.

3 “(C) APPLICATION TO SEVERE OR DIS-
4 ABLING CHRONIC CONDITION SNPS.—Subpara-
5 graph (A) shall only apply to a specialized MA
6 plan for special needs individuals described in
7 subsection (b)(6)(B)(iii) for periods before Jan-
8 uary 1, 2018.”.

9 (b) INCREASED INTEGRATION OF DUAL SNPS.—

10 (1) IN GENERAL.—Section 1859(f) of the Social
11 Security Act (42 U.S.C. 1395w–28(f)) is amended—

12 (A) in paragraph (3), by adding at the end
13 the following new subparagraph:

14 “(F) The plan meets the requirements ap-
15 plicable under paragraph (8).”; and

16 (B) by adding at the end the following new
17 paragraph:

18 “(8) INCREASED INTEGRATION OF DUAL
19 SNPS.—

20 “(A) DESIGNATED CONTACT.—The Sec-
21 retary, acting through the Federal Coordinated
22 Health Care Office (Medicare-Medicaid Coordi-
23 nation Office) established under section 2602 of
24 the Patient Protection and Affordable Care Act
25 (in this paragraph referred to as the ‘MMCO’),

1 shall serve as a dedicated point of contact for
2 States to address misalignments that arise with
3 the integration of specialized MA plans for spe-
4 cial needs individuals described in subsection
5 (b)(6)(B)(ii) under this paragraph. Consistent
6 with such role, the MMCO shall—

7 “(i) establish a uniform process for
8 disseminating to State Medicaid agencies
9 information under this title impacting con-
10 tracts between such agencies and such
11 plans under this subsection; and

12 “(ii) establish basic resources for
13 States interested in exploring such plans
14 as a platform for integration.

15 “(B) UNIFIED APPEALS PROCESS.—

16 “(i) IN GENERAL.—Not later than
17 April 1, 2015, the Secretary shall establish
18 procedures unifying the appeals procedures
19 under sections 1852(g), 1902(a)(3), and
20 1902(a)(5) for items and services provided
21 by specialized MA plans for special needs
22 individuals described in subsection
23 (b)(6)(B)(ii) under this title and title XIX.
24 The Secretary shall solicit comment in de-
25 veloping such procedures from States,

1 plans, beneficiary representatives, and
2 other relevant stakeholders.

3 “(ii) PROCEDURES.—To the extent
4 compatible with a unified process, the pro-
5 cedures established under clause (i) shall—

6 “(I) adopt the most protective
7 provisions for the enrollee under cur-
8 rent law, including continuation of
9 benefits under title XIX pending ap-
10 peal if an appeal is filed in a timely
11 manner;

12 “(II) take into account dif-
13 ferences in State plans under title
14 XIX;

15 “(III) be easily navigable by an
16 enrollee; and

17 “(IV) include the elements de-
18 scribed in clause (iii).

19 “(iii) ELEMENTS DESCRIBED.—The
20 following elements are described in this
21 clause:

22 “(I) Single notification of all ap-
23 plicable appeal rights under this title
24 and title XIX.

1 “(II) Notices written in plain lan-
2 guage and available in a language and
3 format that is accessible to the en-
4 rollee.

5 “(III) Unified timeframes for in-
6 ternal and external appeals processes,
7 such as an individual’s filing of ap-
8 peals, a plan’s acknowledgment and
9 resolution of appeals, and notification
10 of appeals decisions.

11 “(IV) Mechanisms to allow the
12 plan to track and resolve grievances.

13 “(C) REQUIREMENT FOR UNIFIED AP-
14 PEALS.—

15 “(i) IN GENERAL.—For 2016 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 ap-
21 peals procedures as described in subpara-
22 graph (B).

23 “(ii) CONSIDERATION OF APPLICA-
24 TION FOR OTHER SNPS.—The Secretary
25 shall consider applying the unified appeals

1 process described in subparagraph (B) to
2 specialized MA plans for special needs indi-
3 viduals described in subsection (b)(6)(B)(i)
4 and subsection (b)(6)(B)(iii).

5 “(D) REQUIREMENT FOR FULL INTEGRA-
6 TION FOR CERTAIN DUAL SNPS.—

7 “(i) REQUIREMENT.—Subject to the
8 succeeding provisions of this subparagraph,
9 for 2018 and subsequent years, a special-
10 ized MA plan for special needs individuals
11 described in subsection (b)(6)(B)(ii)
12 shall—

13 “(I) integrate all benefits under
14 this title and title XIX; and

15 “(II) meet the requirements of a
16 fully integrated plan described in sec-
17 tion 1853(a)(1)(B)(iv)(II) (other than
18 the requirement that the plan have
19 similar average levels of frailty, as de-
20 termined by the Secretary, as the
21 PACE program), including with re-
22 spect to long-term care services or be-
23 havioral health services to the extent
24 State law permits capitation of those
25 services under such plan.

1 “(ii) INITIAL SANCTIONS FOR FAIL-
2 URE TO MEET REQUIREMENT FOR 2018 OR
3 2019.—For each of 2018 and 2019, if the
4 Secretary determines that a plan has failed
5 to meet the requirement described in
6 clause (i), the Secretary shall impose one
7 of the following on the plan:

8 “(I) A reduction in payments
9 under this part.

10 “(II) Closing enrollment in the
11 plan.

12 “(III) Sanctioning the plan in ac-
13 cordance with section 1857(g).

14 “(IV) Other reasonable action
15 (other than the sanction described in
16 clause (iii)) the Secretary determines
17 appropriate.

18 “(iii) SANCTIONS FOR FAILURE TO
19 MEET REQUIREMENT FOR 2020 AND SUBSE-
20 QUENT YEARS.—For 2020 and subsequent
21 years, if the Secretary determines that a
22 plan has failed to meet the requirement de-
23 scribed in clause (i), the plan shall be
24 deemed to no longer meet the definition of
25 a specialized MA plan for special needs in-

1 individuals described in subsection
2 (b)(6)(B)(ii).

3 “(iv) LIMITATION.—This subpara-
4 graph shall not apply to a specialized MA
5 plan for special needs individuals described
6 in subsection (b)(6)(B)(ii) that only enrolls
7 individuals for whom the only medical as-
8 sistance to which the individuals are enti-
9 tled under the State plan is medicare cost
10 sharing described in section
11 1905(p)(3)(A)(ii).”

12 (2) CONFORMING AMENDMENT TO RESPON-
13 SIBILITIES OF FEDERAL COORDINATED HEALTH
14 CARE OFFICE (MMCO).—Section 2602(d) of the Pa-
15 tient Protection and Affordable Care Act (42 U.S.C.
16 1315b(d)) is amended by adding at the end the fol-
17 lowing new paragraph:

18 “(6) To act as a designated contact for States
19 under subsection (f)(8)(A) of section 1859 of the So-
20 cial Security Act (42 U.S.C. 1395w–28) with respect
21 to the integration of specialized MA plans for special
22 needs individuals described in subsection
23 (b)(6)(B)(ii) of such section.”

24 (c) IMPROVEMENTS TO CARE MANAGEMENT RE-
25 QUIREMENTS FOR SEVERE OR DISABLING CHRONIC CON-

1 DITION SNPS.—Section 1859(f)(5) of the Social Security
2 Act (42 U.S.C. 1395w–28(f)(5)) is amended—

3 (1) by striking “ALL SNPS.—The requirements”
4 and inserting “ALL SNPS.—

5 “(A) IN GENERAL.—Subject to subpara-
6 graph (B), the requirements”;

7 (2) by redesignating subparagraphs (A) and
8 (B) as clauses (i) and (ii), respectively, and indent-
9 ing appropriately;

10 (3) in clause (ii), as redesignated by paragraph
11 (2), by redesignating clauses (i) through (iii) as sub-
12 clauses (I) through (III), respectively, and indenting
13 appropriately; and

14 (4) by adding at the end the following new sub-
15 paragraph:

16 “(B) IMPROVEMENTS TO CARE MANAGE-
17 MENT REQUIREMENTS FOR SEVERE OR DIS-
18 ABLING CHRONIC CONDITION SNPS.—For 2016
19 and subsequent years, in the case of a special-
20 ized MA plan for special needs individuals de-
21 scribed in subsection (b)(6)(B)(iii), the require-
22 ments described in this paragraph include the
23 following:

24 “(i) The interdisciplinary team under
25 subparagraph (A)(ii)(III) includes a team

1 of providers with demonstrated expertise,
2 including training in an applicable spe-
3 cialty, in treating individuals similar to the
4 targeted population of the plan.

5 “(ii) Requirements developed by the
6 Secretary to provide face-to-face encoun-
7 ters with individuals enrolled in the plan.

8 “(iii) As part of the model of care
9 under clause (i) of subparagraph (A), the
10 results of the initial assessment and an-
11 nual reassessment under clause (ii)(I) of
12 such subparagraph of each individual en-
13 rolled in the plan are addressed in the indi-
14 vidual’s individualized care plan under
15 clause (ii)(II) of such subparagraph.

16 “(iv) As part of the annual evaluation
17 and approval of such model of care, the
18 Secretary shall take into account whether
19 the plan fulfilled the previous year’s goals
20 (as required under the model of care).

21 “(v) The Secretary shall establish a
22 minimum benchmark for each element of
23 the model of care of a plan. The Secretary
24 shall only approve a plan’s model of care
25 under this paragraph if each element of

1 the model of care meets the minimum
2 benchmark applicable under the preceding
3 sentence.”.

4 (d) GAO STUDY ON QUALITY IMPROVEMENT.—

5 (1) STUDY.—The Comptroller General of the
6 United States shall conduct a study on how the Sec-
7 retary of Health and Human Services could change
8 the quality measurement system under the Medicare
9 Advantage program under part C of title XVIII of
10 the Social Security Act (42 U.S.C. 1395w–21 et
11 seq.) to allow an accurate comparison of the quality
12 of care provided by specialized MA plans for special
13 needs individuals (as defined in section 1859(b)(6)
14 of such Act (42 U.S.C. 1395w–28(b)(6)), both for
15 individual plans and such plans overall, compared to
16 the quality of care delivered by the original Medicare
17 fee-for-service program under parts A and B of such
18 title and other Medicare Advantage plans under such
19 part C across similar populations.

20 (2) REPORT.—Not later than July 1, 2016, the
21 Comptroller General shall submit to Congress a re-
22 port containing the results of the study under para-
23 graph (1), together with recommendations for such
24 legislation and administrative action as the Comp-
25 troller General determines appropriate.

1 (e) CHANGES TO QUALITY RATINGS AND MEASURE-
2 MENT OF SNPS.—Section 1853(o) of the Social Security
3 Act (42 U.S.C. 1395w–23(o)) is amended by adding at
4 the end the following new paragraph:

5 “(6) CHANGES TO QUALITY RATINGS OF
6 SNPS.—

7 “(A) EMPHASIS ON IMPROVEMENT ACROSS
8 SNPS.—Subject to subparagraph (B), beginning
9 in plan year 2016, in the case of a specialized
10 MA plan for special needs individuals, the Sec-
11 retary shall increase the emphasis on the plan’s
12 improvement or decline in performance when
13 determining the star rating of the plan under
14 this subsection for the year as follows:

15 “(i) At least 25 percent, but not more
16 than 33 percent, of the total star rating of
17 the plan shall be based on improvement or
18 decline in performance.

19 “(ii) Improvement or decline in per-
20 formance under this subparagraph shall be
21 measured based on net change in the indi-
22 vidual star rating measures of the plan,
23 with appropriate weight given to specific
24 individual star ratings measures, such as

1 readmission rates, as determined by the
2 Secretary.

3 “(iii) The Secretary shall make an ap-
4 propriate adjustment to the improvement
5 rating of a plan under this subparagraph
6 if the plan has achieved a 5-star rating or
7 the highest rating possible overall or for an
8 individual measure in order to ensure that
9 the plan is not punished in cases where it
10 is not possible to improve.

11 “(B) NO APPLICATION TO CERTAIN
12 PLANS.—Subparagraph (A) shall not apply,
13 with respect to a year, to a specialized MA plan
14 for special needs individuals that has a rating
15 that does not exceed two-and-one-half stars.

16 “(C) QUALITY MEASUREMENT AT THE
17 PLAN LEVEL.—

18 “(i) IN GENERAL.—The Secretary
19 may require reporting for and apply under
20 this subsection quality measures at the
21 plan level for specialized MA plan for spe-
22 cial needs individuals instead of at the con-
23 tract level.

24 “(ii) CONSIDERATION.—The Secretary
25 shall take into consideration the minimum

1 number of enrollees in a specialized MA
2 plan for special needs individuals in order
3 to determine if a valid measurement of
4 quality at the plan level is possible under
5 clause (i).

6 “(iii) APPLICATION.—If the Secretary
7 applies quality measurement at the plan
8 level under this subparagraph—

9 “(I) such quality measurement
10 shall include Medicare Health Out-
11 comes Survey (HOS), Healthcare Ef-
12 fectiveness Data and Information Set
13 (HEDIS), and Consumer Assessment
14 of Healthcare Providers and Systems
15 (CAHPS) measures; and

16 “(II) payment and other adminis-
17 trative actions linked to quality meas-
18 urement (including the 5-star rating
19 system under this subsection) shall be
20 applied at the plan level in accordance
21 with this subparagraph.”.

1 **SEC. 207. REASONABLE COST REIMBURSEMENT CON-**
2 **TRACTS.**

3 (a) ONE-YEAR TRANSITION AND NOTICE REGARDING
4 TRANSITION.—Section 1876(h)(5)(C) of the Social Secu-
5 rity Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

6 (1) in clause (ii), in the matter preceding sub-
7 clause (I), by striking “For any” and inserting
8 “Subject to clause (iv), for any”; and

9 (2) by adding at the end the following new
10 clauses:

11 “(iv) In the case of an eligible organization that is
12 offering a reasonable cost reimbursement contract that
13 may no longer be extended or renewed because of the ap-
14 plication of clause (ii)—

15 “(I) notwithstanding such clause, such contract
16 may be extended or renewed for one last reasonable
17 cost reimbursement contract year;

18 “(II) the organization may not enroll any new
19 enrollees under such contract during such last rea-
20 sonable cost reimbursement contract year; and

21 “(III) on a date determined by the Secretary
22 prior to the beginning of such last reasonable cost
23 reimbursement contract year, the organization shall
24 provide notice to the Secretary as to whether or not
25 the organization will apply to have the contract con-
26 verted over and offered as a Medicare Advantage

1 plan under part C for the year following such last
2 reasonable cost reimbursement contract year.

3 “(v) If an eligible organization that is offering a rea-
4 sonable cost reimbursement contract that is extended or
5 renewed pursuant to clause (iv) provides the notice de-
6 scribed in clause (iv)(III) that the contract will be con-
7 verted—

8 “(I) the deemed enrollment under section
9 1851(c)(4) shall apply; and

10 “(II) the special rule for quality increases under
11 1853(o)(3)(A)(iv) shall apply.”.

12 (b) DEEMED ENROLLMENT FROM REASONABLE
13 COST REIMBURSEMENT CONTRACTS CONVERTED TO
14 MEDICARE ADVANTAGE PLANS.—

15 (1) IN GENERAL.—Section 1851(c) of the So-
16 cial Security Act (42 U.S.C. 1395w–21(c)) is
17 amended—

18 (A) in paragraph (1), by striking “Such
19 elections” and inserting “Subject to paragraph
20 (4), such elections”; and

21 (B) by adding at the end the following:

22 “(4) DEEMED ENROLLMENT RELATING TO CON-
23 VERTED REASONABLE COST REIMBURSEMENT CON-
24 TRACTS.—

1 “(A) IN GENERAL.—On the first day of
2 the annual, coordinated election period under
3 subsection (e)(3) for plan years beginning on or
4 after January 1, 2016, an MA eligible indi-
5 vidual described in clause (i) or (ii) of subpara-
6 graph (B) is deemed to have elected to receive
7 benefits under this title through an applicable
8 MA plan (and shall be enrolled in such plan)
9 beginning with such plan year, if—

10 “(i) the individual is enrolled in a rea-
11 sonable cost reimbursement contract under
12 section 1876(h) in the previous plan year;

13 “(ii) such reasonable cost reimburse-
14 ment contract was extended or renewed for
15 one last reasonable cost reimbursement
16 contract year pursuant to section
17 1876(h)(5)(C)(iv);

18 “(iii) the eligible organization that is
19 offering such reasonable cost reimburse-
20 ment contract provided the notice de-
21 scribed in subclause (III) of such section
22 that the contract was to be converted;

23 “(iv) the applicable MA plan—

24 “(I) is the plan that was con-
25 verted from the reasonable cost reim-

1 bursement contract described in
2 clause (iii);

3 “(II) is offered by the same enti-
4 ty (or an organization affiliated with
5 such entity) that entered into such
6 contract; and

7 “(III) is offered in the service
8 area where the individual resides;

9 “(v) the amount of the MA monthly
10 basic beneficiary premium for such appli-
11 cable MA plan with respect to the plan
12 year does not exceed monthly premiums
13 under such reasonable cost reimbursement
14 contract for the previous plan year by
15 more than 10 percent;

16 “(vi) the applicable MA plan provides
17 benefits, premiums, and access to providers
18 that are comparable to the benefits, pre-
19 miums, and access to providers under such
20 reasonable cost reimbursement contract for
21 the previous plan year; and

22 “(vii) the applicable MA plan—

23 “(I) allows enrollees transitioning
24 from the converted reasonable cost
25 contract to such plan to maintain cur-

1 rent providers and course of treat-
 2 ment at the time of enrollment for at
 3 least 90 days after enrollment; and

4 “(II) during such period, pays
 5 non-contracting providers for items
 6 and services furnished to the enrollee
 7 an amount that is not less than the
 8 amount of payment applicable for
 9 those items and services under the
 10 original medicare fee-for-service pro-
 11 gram under parts A and B.

12 “(B) MA ELIGIBLE INDIVIDUALS DE-
 13 SCRIBED.—

14 “(i) WITHOUT PRESCRIPTION DRUG
 15 COVERAGE.—An MA eligible individual de-
 16 scribed in this clause, with respect to a
 17 plan year, is an MA eligible individual who
 18 is enrolled in a reasonable cost reimburse-
 19 ment contract under section 1876(h) in the
 20 previous plan year and who does not, for
 21 such previous plan year, receive any pre-
 22 scription drug coverage under part D, in-
 23 cluding coverage under section 1860D–22.

24 “(ii) WITH PRESCRIPTION DRUG COV-
 25 ERAGE.—An MA eligible individual de-

1 scribed in this clause, with respect to a
 2 plan year, is an MA eligible individual who
 3 is enrolled in a reasonable cost reimburse-
 4 ment contract under section 1876(h) in the
 5 previous plan year and who, for such pre-
 6 vious plan year, receives prescription drug
 7 coverage under part D—

8 “(I) through such contract; or

9 “(II) through a prescription drug
 10 plan, if the sponsor of such plan is the
 11 same entity (or an organization affili-
 12 ated with such entity) that entered
 13 into such contract.

14 “(C) APPLICABLE MA PLAN DEFINED.—In
 15 this paragraph, the term ‘applicable MA plan’
 16 means, in the case of an individual described
 17 in—

18 “(i) subparagraph (B)(i), an MA plan
 19 that is not an MA–PD plan; and

20 “(ii) subparagraph (B)(ii), an MA–
 21 PD plan.

22 “(D) IDENTIFICATION OF DEEMED INDI-
 23 VIDUALS.—Not later than 30 days before the
 24 first day of the annual, coordinated election pe-
 25 riod under subsection (e)(3) for plan years be-

1 ginning on or after January 1, 2016, the Sec-
2 retary shall identify the individuals who will be
3 subject to deemed elections under subparagraph
4 (A) on the first day of such period.”.

5 (2) BENEFICIARY OPTION TO DISCONTINUE OR
6 CHANGE MA PLAN OR MA–PD PLAN AFTER DEEMED
7 ENROLLMENT.—

8 (A) IN GENERAL.—Section 1851(e)(2) of
9 the Social Security Act (42 U.S.C. 1395w–
10 21(e)(4)) is amended by adding at the end the
11 following:

12 “(F) SPECIAL PERIOD FOR CERTAIN
13 DEEMED ELECTIONS.—

14 “(i) IN GENERAL.—At any time dur-
15 ing the period beginning after the last day
16 of the annual, coordinated election period
17 under paragraph (3) in which an individual
18 is deemed to have elected to enroll in an
19 MA plan or MA–PD plan under subsection
20 (c)(4) and ending on the last day of Feb-
21 ruary of the first plan year for which the
22 individual is enrolled in such plan, such in-
23 dividual may change the election under
24 subsection (a)(1) (including changing the

1 MA plan or MA–PD plan in which the in-
2 dividual is enrolled).

3 “(ii) LIMITATION OF ONE CHANGE.—

4 An individual may exercise the right under
5 clause (i) only once during the applicable
6 period described in such clause. The limita-
7 tion under this clause shall not apply to
8 changes in elections effected during an an-
9 nual, coordinated election period under
10 paragraph (3) or during a special enroll-
11 ment period under paragraph (4).”.

12 (B) CONFORMING AMENDMENTS.—

13 (i) PLAN REQUIREMENT FOR OPEN
14 ENROLLMENT.—Section 1851(e)(6)(A) of
15 the Social Security Act (42 U.S.C. 1395w-
16 21(e)(6)(A)) is amended by striking “para-
17 graph (1),” and inserting “paragraph (1),
18 during the period described in paragraph
19 (2)(F),”.

20 (ii) PART D.—Section 1860D-
21 1(b)(1)(B) of such Act (42 U.S.C. 1395w-
22 101(b)(1)(B)) is amended—

23 (I) in clause (ii), by adding “and
24 paragraph (4)” after “paragraph
25 (3)(A)”; and

1 (II) in clause (iii) by striking
2 “and (E)” and inserting “(E), and
3 (F)”.

4 (3) TREATMENT OF ESRD FOR DEEMED EN-
5 ROLLMENT.—Section 1851(a)(3)(B) of the Social
6 Security Act (42 U.S.C. 1395w–21(a)(3)(B)) is
7 amended by adding at the end the following flush
8 sentence:

9 “An individual who develops end-stage renal
10 disease while enrolled in a reasonable cost reim-
11 bursement contract under section 1876(h) shall
12 be treated as an MA eligible individual for pur-
13 poses of applying the deemed enrollment under
14 subsection (c)(4).”.

15 (c) INFORMATION REQUIREMENTS.—Section
16 1851(d)(2)(B) of the Social Security Act (42 U.S.C.
17 1395w–21(d)(2)(B)) is amended—

18 (1) by striking the subparagraph heading and
19 inserting the following: “(i) NOTIFICATION TO
20 NEWLY ELIGIBLE MEDICARE ADVANTAGE ELIGIBLE
21 INDIVIDUALS.—”; and

22 (2) by adding at the end the following:

23 “(ii) NOTIFICATION RELATED TO CERTAIN
24 DEEMED ELECTIONS.—The Secretary shall, not
25 later than 15 days prior to the first day of the

1 annual, coordinated election period under sub-
2 section (e)(3) of a year, mail to any individual
3 identified by the Secretary under subsection
4 (c)(4)(D) for such year—

5 “(I) a notification that such individual
6 will, on such day, be deemed to have made
7 an election to receive benefits under this
8 title through an MA plan or MA–PD plan
9 (and shall be enrolled in such plan) for the
10 next plan year under subsection (c)(4)(A),
11 but that the individual may make a dif-
12 ferent election during the annual, coordi-
13 nated election period for such year;

14 “(II) the information described in
15 subparagraph (A);

16 “(III) a description of the differences
17 between such MA plan or MA–PD plan
18 and the reasonable cost reimbursement
19 contract in which the individual was most
20 recently enrolled with respect to benefits
21 covered under such plans, including cost-
22 sharing, premiums, drug coverage, and
23 provider networks; and

1 “(IV) information about the special
2 period for elections under subsection
3 (e)(2)(F).”.

4 (d) TREATMENT OF TRANSITION PLAN FOR QUALITY
5 RATING FOR PAYMENT PURPOSES.—Section
6 1853(o)(3)(A) of the Social Security Act (42 U.S.C.
7 1395w–23(o)(3)(A)) is amended by adding at the end the
8 following new clause:

9 “(iv) SPECIAL RULE FOR FIRST 2
10 PLAN YEARS FOR PLANS THAT WERE CON-
11 VERTED FROM A REASONABLE COST REIM-
12 BURSEMENT CONTRACT.—In applying
13 paragraph (1) for the first 2 plan years
14 under this part in the case of a plan that
15 is a new MA plan (as defined in clause
16 (iii)(II)) to which deemed enrollment ap-
17 plies under section 1851(e)(4), the Sec-
18 retary shall use the star rating that ap-
19 plied to the converted reasonable cost reim-
20 bursement contract for the year preceding
21 the first plan year for such plan under this
22 part.”.

1 **SEC. 208. QUALITY MEASURE ENDORSEMENT AND SELEC-**
 2 **TION.**

3 (a) CONTRACT WITH AN ENTITY REGARDING INPUT
 4 ON THE SELECTION OF MEASURES.—

5 (1) IN GENERAL.—Title XVIII of the Social Se-
 6 curity Act (42 U.S.C. 1395 et seq.) is amended—

7 (A) by redesignating section 1890A as sec-
 8 tion 1890B; and

9 (B) by inserting after section 1890 the fol-
 10 lowing new section:

11 “CONTRACT WITH AN ENTITY REGARDING INPUT ON THE
 12 SELECTION OF MEASURES

13 “SEC. 1890A (a) CONTRACT.—

14 “(1) IN GENERAL.—For purposes of activities
 15 conducted under this Act, the Secretary shall iden-
 16 tify and have in effect a contract with an entity that
 17 meets the requirements described in subsection (c).
 18 Such contract shall provide that the entity will per-
 19 form the duties described in subsection (b).

20 “(2) TIMING FOR FIRST CONTRACT.—The first
 21 contract under paragraph (1) shall begin on October
 22 1, 2014.

23 “(3) PERIOD OF CONTRACT.—A contract under
 24 paragraph (1) shall be for a period of 3 years (ex-
 25 cept as may be renewed after a subsequent bidding
 26 process).

1 “(4) COMPETITIVE PROCEDURES.—Competitive
2 procedures (as defined in section 4(5) of the Office
3 of Federal Procurement Policy Act (41 U.S.C.
4 403(5))) shall be used to enter into a contract under
5 paragraph (1).

6 “(b) DUTIES.—The duties described in this sub-
7 section are the following:

8 “(c) REQUIREMENTS DESCRIBED.—The require-
9 ments described in this subsection are the following:

10 “(1) PRIVATE NONPROFIT, BOARD MEMBER-
11 SHIP, MEMBERSHIP FEES, AND NOT A MEASURE DE-
12 VELOPER.—The requirements described in para-
13 graphs (1), (2), (7), and (8) of section 1890(c).

14 “(2) EXPERIENCE.—The entity has at least 4
15 years of experience working with quality and effi-
16 ciency measures.”.

17 (2) DUTIES OF ENTITY.—

18 (A) TRANSFER OF PRIORITY SETTING
19 PROCESS.—Paragraph (1) of section 1890(b) of
20 the Social Security Act (42 U.S.C. 1395aaa(b))
21 is redesignated as paragraph (1) of section
22 1890A(b) of such Act, as added by paragraph
23 (1).

24 (B) TRANSFER OF MULTI-STAKEHOLDER
25 PROCESS.—Paragraphs (7) and (8) of such sec-

1 tion 1890(b) are redesignated as paragraphs
2 (2) and (3), respectively, of section 1890A(b) of
3 such Act, as added by paragraph (1) and
4 amended by subparagraph (A).

5 (C) ADDITIONAL DUTIES.—Section
6 1890A(b) of such Act, as added by paragraph
7 (1) and amended by subparagraphs (A) and
8 (B), is amended by adding at the end the fol-
9 lowing new paragraphs:

10 “(4) FACILITATION TO BETTER COORDINATE
11 AND ALIGN PUBLIC AND PRIVATE SECTOR USE OF
12 QUALITY MEASURES.—

13 “(A) IN GENERAL.—The entity shall facili-
14 tate increased coordination and alignment be-
15 tween the public and private sector with respect
16 to quality and efficiency measures.

17 “(B) REPORTS.—The entity shall prepare
18 and make available to the public annual reports
19 on its findings under this paragraph. Such pub-
20 lic availability shall include posting each report
21 on the Internet website of the entity.

22 “(5) GAP ANALYSIS.—The entity shall conduct
23 an ongoing analysis of—

24 “(A) gaps in endorsed quality and effi-
25 ciency measures, which shall include measures

1 that are within priority areas identified by the
2 Secretary under the national strategy estab-
3 lished under section 399HH of the Public
4 Health Service Act; and

5 “(B) areas where quality measures are un-
6 available or inadequate to identify or address
7 such gaps.

8 “(6) ANNUAL REPORT TO CONGRESS AND THE
9 SECRETARY; SECRETARIAL PUBLICATION AND COM-
10 MENT.—

11 “(A) ANNUAL REPORT.—By not later than
12 March 1 of each year, the entity shall submit
13 to Congress and the Secretary a report con-
14 taining—

15 “(i) a description of—

16 “(I) the recommendations made
17 under paragraph (1);

18 “(II) the matters described in
19 clauses (i) and (ii) of paragraph
20 (2)(A);

21 “(III) the results of the analysis
22 under paragraph (5); and

23 “(IV) the performance by the en-
24 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) for a year, 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 (D) ADDITIONAL AMENDMENTS.—Section
14 1890A(b) of such Act, as so added and amend-
15 ed, is amended—

16 (i) in paragraph (2)—

17 (I) in the heading of subpara-
18 graph (B) by inserting “AND EFFI-
19 CIENCY” after “QUALITY”;

20 (II) in subparagraph (B)(i)(III),
21 by striking “this Act” and inserting
22 “this title”; and

23 (III) by adding at the end the
24 following new subparagraphs:

1 “(E) INPUT.—In providing the input de-
2 scribed in subparagraph (A), the multi-stake-
3 holder groups—

4 “(i) shall include a detailed descrip-
5 tion of the rationale for each recommenda-
6 tion made by the multi-stakeholder group,
7 including in areas relating to—

8 “(I) the expected impact that im-
9 plementing the measure will have on
10 individuals;

11 “(II) the burden on providers of
12 services and suppliers;

13 “(III) the expected influence over
14 the behavior of providers of services
15 and suppliers;

16 “(IV) the applicability of a meas-
17 ure for more than one setting or pro-
18 gram; and

19 “(V) other areas determined in
20 consultation with the Secretary; and

21 “(ii) may consider whether it is appro-
22 priate to provide separate recommenda-
23 tions with respect to measures for internal
24 use, public reporting, and payment provi-
25 sions.

1 “(F) EQUAL REPRESENTATION.—In con-
2 vening multi-stakeholder groups pursuant to
3 this paragraph, the entity shall, to the extent
4 feasible, make every effort to ensure such
5 groups are balanced across stakeholders.”; and

6 (ii) in paragraph (3), by striking “Not
7 later” and all that follows through the pe-
8 riod at the end and inserting the following:
9 “Not later than the applicable dates de-
10 scribed in section 1890B(a)(3) of each
11 year (or, as applicable, the timeframe de-
12 scribed in section 1890A(a)(4)), the entity
13 shall transmit to the Secretary the input of
14 the multi-stakeholder group under para-
15 graph (2).”.

16 (b) REVISIONS TO CONTRACT WITH CONSENSUS-
17 BASED ENTITY.—

18 (1) CONTRACT.—Section 1890(a) of the Social
19 Security Act (42 U.S.C. 1395aaa(a)) is amended—

20 (A) in paragraph (1), by striking “, such
21 as the National Quality Forum,”; and

22 (B) in paragraph (3), by striking “4
23 years” and inserting “3 years”.

1 (2) DUTIES.—Section 1890(b) of the Social Se-
2 curity Act (42 U.S.C. 1395aaa(b)), as amended by
3 subsection (a)(2), is amended—

4 (A) by redesignating paragraphs (2) and
5 (3) as paragraphs (1) and (2), respectively;

6 (B) in paragraph (2), as redesignated by
7 subparagraph (A), by striking “paragraph (2)”
8 and inserting “paragraph (1)”;

9 (C) by striking paragraphs (5) and (6);
10 and

11 (D) by adding at the end the following new
12 paragraphs:

13 “(3) FACILITATION TO BETTER COORDINATE
14 AND ALIGN PUBLIC AND PRIVATE SECTOR USE OF
15 QUALITY MEASURES.—

16 “(A) IN GENERAL.—The entity shall facili-
17 tate increased coordination and alignment be-
18 tween the public and private sector with respect
19 to quality and efficiency measures.

20 “(B) REPORTS.—The entity shall prepare
21 and make available to the public annual reports
22 on its findings under this paragraph. Such pub-
23 lic availability shall include posting each report
24 on the Internet website of the entity.

1 “(4) ANNUAL REPORT TO CONGRESS AND THE
2 SECRETARY; SECRETARIAL PUBLICATION AND COM-
3 MENT.—

4 “(A) ANNUAL REPORT.—By not later than
5 March 1 of each year, the entity shall submit
6 to Congress and the Secretary a report con-
7 taining—

8 “(i) a description of—

9 “(I) the coordination of quality
10 initiatives under this Act with quality
11 initiatives implemented by other pay-
12 ers;

13 “(II) areas in which evidence is
14 insufficient to support endorsement of
15 quality measures in priority areas
16 identified by the Secretary under the
17 national strategy established under
18 section 399HH of the Public Health
19 Service Act and where targeted re-
20 search may address such gaps; and

21 “(III) 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) for a year, 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 (3) REQUIREMENTS.—Section 1890(e) of the
12 Social Security Act (42 U.S.C. 1395aaa(c)) is
13 amended by adding at the end the following new
14 paragraph:

15 “(8) NOT A MEASURE DEVELOPER.—The entity
16 is not a measure developer.”.

17 (c) REVISIONS TO DUTIES OF THE SECRETARY RE-
18 GARDING USE OF MEASURES.—

19 (1) IN GENERAL.—Section 1890B(a) of the So-
20 cial Security Act (42 U.S.C. 1395aaa–1(a)), as re-
21 designated by subsection (a)(1)(A), is amended—

22 (A) by striking “section 1890(b)(7)(B)”
23 each place it appears and inserting “section
24 1890A(b)(2)(B)”;

25 (B) in paragraph (1)—

1 (i) by striking “section 1890(b)(7)”
2 and inserting “section 1890A(b)(2)”; and

3 (ii) by striking “section 1890” and in-
4 sserting “section 1890A”;

5 (C) by striking paragraphs (2) and (3) and
6 inserting the following:

7 “(2) PUBLIC AVAILABILITY OF MEASURES CON-
8 sidered for selection.—Subject to paragraph
9 (4), not later than October 1 or December 31 of
10 each year, the Secretary shall make available to the
11 public a list of quality and efficiency measures de-
12 scribed in section 1890A(b)(2)(B) that the Secretary
13 is considering under this title. The Secretary shall
14 provide for an appropriate balance of the number of
15 measures to be made available by each such date in
16 a year.

17 “(3) TRANSMISSION OF MULTI-STAKEHOLDER
18 INPUT.—

19 “(A) IN GENERAL.—Subject to paragraph
20 (4), not later than the applicable date described
21 in subparagraph (B) of each year, the entity
22 with a contract under section 1890A shall, pur-
23 suant to subsection (b)(3) of such section,
24 transmit to the Secretary the input of multi-
25 stakeholder groups described in paragraph (1).

1 “(B) APPLICABLE DATE DESCRIBED.—The
2 applicable date described in this subparagraph
3 for a year is—

4 “(i) February 1 with respect to qual-
5 ity and efficiency measures made available
6 under paragraph (2) by October 1 of the
7 preceding year; and

8 “(ii) April 1 with respect to quality
9 and efficiency measures made available
10 under paragraph (2) by December 31 of
11 the preceding year.”;

12 (D) by redesignating—

13 (i) paragraph (6) as paragraph (8);

14 and

15 (ii) paragraphs (4) and (5) as para-
16 graphs (5) and (6), respectively;

17 (E) by inserting after paragraph (3) the
18 following new paragraph:

19 “(4) LIMITED PROCESS FOR ADDITIONAL
20 MULTI-STAKEHOLDER INPUT.—In addition to the
21 Secretary making measures publically available pur-
22 suant to the dates described in paragraph (2) and
23 multi-stakeholder groups transmitting the input pur-
24 suant to the applicable dates described in paragraph
25 (3)—

1 “(A) the Secretary may, at times that do
2 not meet the time requirements described in
3 paragraph (2), make available to the public a
4 limited number of quality and efficiency meas-
5 ures described in section 1890A(b)(2) that the
6 Secretary is considering under this title; and

7 “(B) if the Secretary uses the authority
8 under subparagraph (A), the entity with a con-
9 tract under section 1890A shall, pursuant to
10 section 1890A(b)(3), transmit to the Secretary
11 on a timely basis the input from a multi-stake-
12 holder group described in paragraph (1) with
13 respect to such measures.”;

14 (F) in paragraph (6), as redesignated by
15 subparagraph (D)(ii), by inserting “or that has
16 not been recommended by the multi-stakeholder
17 group under section 1890A(b)(2)” before the
18 period at the end; and

19 (G) by inserting after paragraph (6) the
20 following new paragraph:

21 “(7) CONCORDANCE RATES.—For each year
22 (beginning with 2015), the Secretary shall include a
23 list of concordance rates for each type of provider of
24 services and supplier in the annual final rule appli-
25 cable to such type of provider or supplier.”.

1 (2) REVIEW.—Section 1890B(c) of the Social
2 Security Act (42 U.S.C. 1395aaa–1(c)), as redesign-
3 nated by subsection (a)(1)(A), is amended—

4 (A) in paragraph (1)(A), by striking “sec-
5 tion 1890(b)(7)(B)” and inserting “section
6 1890A(b)(2)(B)”; and

7 (B) in paragraph (2)—

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

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

13 (iii) by adding at the end the fol-
14 lowing new subparagraph:

15 “(C) take into consideration the benefits of
16 the alignment of measures between the public
17 and private sector.”.

18 (d) FUNDING FOR QUALITY MEASURE ENDORSE-
19 MENT AND SELECTION.—

20 (1) FISCAL YEAR 2014.—In addition to amounts
21 transferred under section 3014(c) of the Patient
22 Protection and Affordable Care Act (Public Law
23 111–148), for purposes of carrying out section 1890
24 and section 1890A (other than subsections (e) and
25 (f)), the Secretary shall provide for the transfer,

1 from the Federal Hospital Insurance Trust Fund
2 under section 1817 and the Federal Supplementary
3 Medical Insurance Trust Fund under section 1841,
4 in such proportion as the Secretary determines ap-
5 propriate, to the Centers for Medicare & Medicaid
6 Services Program Management Account of
7 \$7,000,000 for fiscal year 2014. Amounts trans-
8 ferred under the preceding sentence shall remain
9 available until expended.

10 (2) FISCAL YEARS 2015 THROUGH 2017.—Sec-
11 tion 1890B of the Social Security Act (42 U.S.C.
12 1395aaa-1), as redesignated by subsection
13 (a)(1)(A), is amended by adding at the end the fol-
14 lowing new subsection:

15 “(g) FUNDING.—

16 “(1) IN GENERAL.—For purposes of carrying
17 out this section (other than subsections (e) and (f))
18 and sections 1890 and 1890A, the Secretary shall
19 provide for the transfer, from the Federal Hospital
20 Insurance Trust Fund under section 1817 and the
21 Federal Supplementary Medical Insurance Trust
22 Fund under section 1841, in such proportion as the
23 Secretary determines appropriate, to the Centers for
24 Medicare & Medicaid Services Program Management

1 Account of \$25,000,000 for each of fiscal years
2 2015 through 2017.

3 “(2) AVAILABILITY.—Amounts transferred
4 under paragraph (1) shall remain available until ex-
5 pended.”.

6 (3) CONFORMING AMENDMENT.—Subsection (d)
7 of section 1890 of the Social Security Act (42
8 U.S.C. 1395aaa) is repealed.

9 (e) CONFORMING AMENDMENTS.—(1) Section
10 1848(m)(3)(E)(iii) of the Social Security Act (42 U.S.C.
11 1395w-4(m)(3)(E)(iii)) is amended by striking “section
12 1890(b)(7) and 1890A(a)” and inserting “section
13 1890A(b)(2) and 1890B(a)”.

14 (2) Section 1866D(b)(2)(C) of the Social Security
15 Act (42 U.S.C. 1395cc-4(b)(2)(C)) is amended by striking
16 “section 1890 and 1890A” and inserting “sections 1890,
17 1890A, and 1890B”.

18 (3) Section 1899A(n)(2)(A) of the Social Security
19 Act (42 U.S.C. 1395cc-4(n)(2)(A)) is amended by strik-
20 ing “section 1890(b)(7)(B)” and inserting “section
21 1890A(b)(2)(B)”.

22 (f) EFFECTIVE DATE.—

23 (1) IN GENERAL.—The amendments made by
24 this section shall take effect on October 1, 2014,
25 and shall apply with respect to contract periods

1 under sections 1890 and 1890A of the Social Secu-
2 rity Act that begin on or after such date.

3 (2) NEW CONTRACTS BEGINNING WITH FISCAL
4 YEAR 2015.—The Secretary of Health and Human
5 Services shall enter into a new contract under both
6 sections 1890 and 1890A of the Social Security Act,
7 as amended by this Act, for a contract period begin-
8 ning on October 1, 2014.

9 **SEC. 209. PERMANENT EXTENSION OF FUNDING OUTREACH**
10 **AND ASSISTANCE FOR LOW-INCOME PRO-**
11 **GRAMS.**

12 (a) ADDITIONAL FUNDING FOR STATE HEALTH IN-
13 SURANCE PROGRAMS.—Subsection (a)(1)(B)(iii) of sec-
14 tion 119 of the Medicare Improvements for Patients and
15 Providers Act of 2008 (42 U.S.C. 1395b–3 note), as
16 amended by section 3306 of the Patient Protection and
17 Affordable Care Act (Public Law 111–148) and section
18 610 of the American Taxpayer Relief Act of 2012 (Public
19 Law 112–240), is amended by inserting “and for each
20 subsequent fiscal year” after “fiscal year 2013”.

21 (b) ADDITIONAL FUNDING FOR AREA AGENCIES ON
22 AGING.—Subsection (b)(1)(B) of such section 119, as so
23 amended, is amended by inserting “and for each subse-
24 quent fiscal year” after “fiscal year 2013”.

1 (c) ADDITIONAL FUNDING FOR AGING AND DIS-
2 ABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of
3 such section 119, as so amended, is amended by inserting
4 “and for each subsequent fiscal year” after “fiscal year
5 2013”.

6 (d) ADDITIONAL FUNDING FOR CONTRACT WITH
7 THE NATIONAL CENTER FOR BENEFITS AND OUTREACH
8 ENROLLMENT.—Subsection (d)(2) of such section 119, as
9 so amended, is amended by inserting “and for each subse-
10 quent fiscal year” after “fiscal year 2013”.

11 **Subtitle B—Medicaid and Other** 12 **Extensions**

13 **SEC. 211. QUALIFYING INDIVIDUAL PROGRAM.**

14 (a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the
15 Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is
16 amended by striking “December 2013” and inserting “De-
17 cember 2018”.

18 (b) ELIMINATING LIMITATIONS ON ELIGIBILITY.—
19 Section 1933 of the Social Security Act (42 U.S.C.
20 1396u–3) is amended by striking subsections (b) and (e).

21 (c) ELIMINATING ALLOCATIONS.—Section 1933 of
22 the Social Security Act (42 U.S.C. 1396u–3) is amended
23 by striking subsections (e) and (g).

24 (d) CONFORMING AMENDMENTS.—

1 (1) IN GENERAL.—Section 1933 of the Social
2 Security Act (42 U.S.C. 1396u–3), as amended by
3 subsections (b) and (c), is further amended—

4 (A) by striking subsection (a) and insert-
5 ing the following new subsection:

6 “(a) APPLICABLE FMAP.—With respect to assist-
7 ance described in section 1902(a)(10)(E)(iv) furnished in
8 a State, the Federal medical assistance percentage shall
9 be equal to 100 percent.”;

10 (B) by striking subsection (d); and

11 (C) by redesignating subsection (f) as sub-
12 section (b).

13 (2) DEFINITION OF FMAP.—Section 1905(b) of
14 the Social Security Act (42 U.S.C. 1396d(b)) is
15 amended by striking “section 1933(d)” and insert-
16 ing “section 1933(a)”.

17 (e) EFFECTIVE DATE.—The amendments made by
18 this section shall take effect on January 1, 2014, and shall
19 apply with respect to calendar quarters beginning on or
20 after such date.

21 **SEC. 212. TRANSITIONAL MEDICAL ASSISTANCE.**

22 (a) EXTENSION.—Sections 1902(e)(1)(B) and
23 1925(f) of the Social Security Act (42 U.S.C.
24 1396a(e)(1)(B), 1396r–6(f)) are each amended by strik-

1 ing “December 31, 2013” and inserting “December 31,
2 2018”.

3 (b) OPT-OUT OPTION FOR STATES THAT EXPAND
4 ADULT COVERAGE AND PROVIDE 12-MONTH CONTINUOUS
5 ELIGIBILITY UNDER MEDICAID AND CHIP.—

6 (1) IN GENERAL.—Section 1925 of the Social
7 Security Act (42 U.S.C. 1396r–6), as amended by
8 subsection (a), is further amended—

9 (A) in subsection (a)—

10 (i) in paragraph (1)(A), by striking
11 “paragraph (5)” and inserting “para-
12 graphs (5) and (6)”; and

13 (ii) by adding at the end the fol-
14 lowing:

15 “(6) OPT-OUT OPTION FOR STATES THAT EX-
16 PAND ADULT COVERAGE AND PROVIDE 12-MONTH
17 CONTINUOUS ELIGIBILITY UNDER MEDICAID AND
18 CHIP.—

19 “(A) IN GENERAL.—In the case of a State
20 described in subparagraph (B), the State may
21 elect through a State plan amendment to have
22 this section and sections 408(a)(11)(A),
23 1902(a)(52), 1902(e)(1), and 1931(c)(2) not
24 apply to the State.

1 “(B) STATE DESCRIBED.—A State is de-
2 scribed in this subparagraph if the State is one
3 of the 50 States or the District of Columbia
4 and—

5 “(i) has elected to provide medical as-
6 sistance to individuals under subclause
7 (VIII) of section 1902(a)(10)(A)(i);

8 “(ii) has elected under section
9 1902(e)(12)(A) the option to provide con-
10 tinuous eligibility for a 12-month period
11 for individuals under 19 years of age;

12 “(iii) has elected under section
13 1902(e)(12)(B) the option to provide con-
14 tinuous eligibility for a 12-month period
15 for all categories of individuals described in
16 that section; and

17 “(iv) has elected to apply section
18 1902(e)(12)(A) to the State child health
19 plan under title XXI.”; and

20 (B) in subsection (b)(1), by striking “sub-
21 section (a)(5)” and inserting “paragraphs (5)
22 and (6) of subsection (a)”.

23 (2) CONFORMING AMENDMENT TO 4-MONTH RE-
24 QUIREMENT.—Section 1902(e)(1) of the Social Se-

1 security Act (42 U.S.C. 1396a(e)(1)), as amended by
2 subsection (a), is further amended—

3 (A) in subparagraph (B), by striking
4 “Subparagraph (A)” and inserting “Subject to
5 subparagraph (C), subparagraph (A)”; and

6 (B) by adding at the end the following:

7 “(C) If a State has made an election under section
8 1925(a)(6), subparagraph (A) and section 1925 shall not
9 apply to the State.”.

10 (c) EXTENSION OF 12-MONTH CONTINUOUS ELIGI-
11 BILITY OPTION TO CERTAIN ADULT ENROLLEES UNDER
12 MEDICAID; CLARIFICATION OF APPLICATION TO CHIP.—

13 (1) IN GENERAL.—Section 1902(e)(12) of the
14 Social Security Act (42 U.S.C. 1396a(e)(12)) is
15 amended—

16 (A) by redesignating subparagraphs (A)
17 and (B) as clauses (i) and (ii), respectively;

18 (B) by inserting “(A)” after “(12)”; and

19 (C) by adding at the end the following:

20 “(B) At the option of the State, the plan may provide
21 that an individual who is determined to be eligible for ben-
22 efits under a State plan approved under this title under
23 any of the following eligibility categories, or who is rede-
24 termined to be eligible for such benefits under any of such
25 categories, shall be considered to meet the eligibility re-

1 requirements met on the date of application and shall re-
 2 main eligible for those benefits until the end of the 12-
 3 month period following the date of the determination or
 4 redetermination of eligibility:

5 “(i) Section 1902(a)(10)(A)(i)(VIII).

6 “(ii) Section 1931.”.

7 (2) APPLICATION TO CHIP.—Section 2107(e)(1)
 8 of the Social Security Act (42 U.S.C. 1397gg(e)(1))
 9 is amended—

10 (A) by redesignating subparagraphs (E)
 11 through (O) as subparagraphs (F) through (P),
 12 respectively; and

13 (B) by inserting after subparagraph (D),
 14 the following:

15 “(E) Section 1902(e)(12)(A) (relating to
 16 the State option for 12-month continuous eligi-
 17 bility and enrollment).”.

18 (d) CONFORMING AND TECHNICAL AMENDMENTS
 19 RELATING TO SECTION 1931 TRANSITIONAL COVERAGE
 20 REQUIREMENTS.—

21 (1) IN GENERAL.—Section 1931(c) of the So-
 22 cial Security Act (42 U.S.C. 1396u-1(c)) is amend-
 23 ed—

24 (A) in paragraph (1)—

1 (i) in the paragraph heading, by strik-
2 ing “CHILD” and inserting “SPOUSAL”;

3 (ii) by striking “The provisions” and
4 inserting “Subject to paragraph (3), the
5 provisions”; and

6 (iii) by striking “child or”;

7 (B) in paragraph (2), by striking “For
8 continued” and inserting “Subject to paragraph
9 (3), for continued”; and

10 (C) by adding at the end the following:

11 “(3) OPT-OUT OPTION FOR STATES THAT EX-
12 PAND ADULT COVERAGE AND PROVIDE 12-MONTH
13 CONTINUOUS ELIGIBILITY UNDER MEDICAID AND
14 CHIP.—

15 “(A) IN GENERAL.—In the case of a State
16 described in subparagraph (B), the State may
17 elect through a State plan amendment to have
18 paragraphs (1) and (2) of this subsection and
19 sections 408(a)(11), 1902(a)(52), 1902(e)(1),
20 and 1925 not apply to the State.

21 “(B) STATE DESCRIBED.—A State is de-
22 scribed in this subparagraph if the State is one
23 of the 50 States or the District of Columbia
24 and—

1 “(i) has elected to provide medical as-
2 sistance to individuals under subclause
3 (VIII) of section 1902(a)(10)(A)(i);

4 “(ii) has elected under section
5 1902(e)(12)(A) the option to provide con-
6 tinuous eligibility for a 12-month period
7 for individuals under 19 years of age;

8 “(iii) has elected under section
9 1902(e)(12)(B) the option to provide con-
10 tinuous eligibility for a 12-month period
11 for all categories of individuals described in
12 that section; and

13 “(iv) has elected to apply section
14 1902(e)(12)(A) to the State child health
15 plan under title XXI.”.

16 (2) CONFORMING AMENDMENT TO SECTION
17 408.—Section 408(a)(11) of the Social Security Act
18 (42 U.S.C. 608(a)(11) is amended—

19 (A) in the paragraph heading, by striking
20 “CHILD” and inserting “SPOUSAL”; and

21 (B) in subparagraph (B)—

22 (i) in the subparagraph heading, by
23 striking “CHILD” and inserting “SPOUS-
24 AL”; and

25 (ii) by striking “child or”.

1 (e) CONFORMING AMENDMENT RELATING TO MAIN-
2 TENANCE OF EFFORT FOR CHILDREN.—Section
3 1902(gg)(4) of the Social Security Act (42 U.S.C.
4 1396a(gg)(4)) is amended by adding at the end the fol-
5 lowing:

6 “(C) STATES THAT EXPAND ADULT COV-
7 ERAGE AND ELECT TO OPT-OUT OF TRANSI-
8 TIONAL COVERAGE.—

9 “(i) IN GENERAL.—For purposes of
10 determining compliance with the require-
11 ments of paragraph (2), a State which ex-
12 ercises the option under sections
13 1925(a)(6) and 1931(e)(3) to provide no
14 transitional medical assistance or other ex-
15 tended eligibility (as applicable) shall not,
16 as a result of exercising such option, be
17 considered to have in effect eligibility
18 standards, methodologies, or procedures
19 described in clause (ii) that are more re-
20 strictive than the standards, methodolo-
21 gies, or procedures in effect under the
22 State plan or under a waiver of the plan
23 on the date of enactment of the Patient
24 Protection and Affordable Care Act.

1 “(ii) STANDARDS, METHODOLOGIES,
2 OR PROCEDURES DESCRIBED.—The eligi-
3 bility standards, methodologies, or proce-
4 dures described in this clause are those
5 standards, methodologies, or procedures
6 applicable to determining the eligibility for
7 medical assistance of any child under 19
8 years of age (or such higher age as the
9 State may have elected).”.

10 (f) EFFECTIVE DATE.—The amendments made by
11 this section shall take effect on January 1, 2014.

12 **SEC. 213. EXPRESS LANE ELIGIBILITY.**

13 Section 1902(e)(13)(I) of the Social Security Act (42
14 U.S.C. 1396a(e)(13)(I)) is amended by striking “Sep-
15 tember 30, 2014” and inserting “September 30, 2015”.

16 **SEC. 214. PEDIATRIC QUALITY MEASURES.**

17 (a) CONTINUATION OF FUNDING FOR PEDIATRIC
18 QUALITY MEASURES FOR IMPROVING THE QUALITY OF
19 CHILDREN’S HEALTH CARE.—Section 1139B(e) of the
20 Social Security Act (42 U.S.C. 1320b–9b(e)) is amended
21 by adding at the end the following: “Of the funds appro-
22 priated under this subsection, not less than \$15,000,000
23 shall be used to carry out section 1139A(b).”.

24 (b) ELIMINATION OF RESTRICTION ON MEDICAID
25 QUALITY MEASUREMENT PROGRAM.—Section

1 1139B(b)(5)(A) of the Social Security Act (42 U.S.C.
2 1320b–9b(b)(5)(A)) is amended by striking “The aggre-
3 gate amount awarded by the Secretary for grants and con-
4 tracts for the development, testing, and validation of
5 emerging and innovative evidence-based measures under
6 such program shall equal the aggregate amount awarded
7 by the Secretary for grants under section
8 1139A(b)(4)(A)”.

9 **SEC. 215. SPECIAL DIABETES PROGRAMS.**

10 (a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-
11 BETES.—Section 330B(b)(2)(C) of the Public Health
12 Service Act (42 U.S.C. 254e–2(b)(2)(C)) is amended by
13 striking “2014” and inserting “2019”.

14 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—
15 Section 330C(c)(2)(C) of the Public Health Service Act
16 (42 U.S.C. 254e–3(c)(2)(C)) is amended by striking
17 “2014” and inserting “2019”.

18 **Subtitle C—Human Services**

19 **Extensions**

20 **SEC. 221. ABSTINENCE EDUCATION GRANTS.**

21 (a) IN GENERAL.—Section 510 of the Social Security
22 Act (42 U.S.C. 710) is amended—

23 (1) in subsection (a), in the matter preceding
24 paragraph (1), by striking “2010 through 2014”
25 and inserting “2015 through 2019”; and

1 (2) in subsection (d)—

2 (A) by striking “2010 through 2014” and
3 inserting “2015 through 2019”; and

4 (B) by striking the second sentence.

5 (b) EFFECTIVE DATE.—The amendments made by
6 this section shall take effect on October 1, 2014.

7 **SEC. 222. PERSONAL RESPONSIBILITY EDUCATION PRO-**
8 **GRAM.**

9 (a) IN GENERAL.—Section 513 of the Social Security
10 Act (42 U.S.C. 713) is amended—

11 (1) in subsection (a)—

12 (A) in paragraph (1)(A), by striking “2010
13 through 2014” and inserting “2015 through
14 2019”;

15 (B) in paragraph (4)—

16 (i) in subparagraph (A)—

17 (I) by striking “2010 or 2011”
18 and inserting “2015 or 2016”;

19 (II) by striking “2010 through
20 2014” and inserting “2015 through
21 2019”; and

22 (III) by striking “2012 through
23 2014” and inserting “2017 through
24 2019”; and

25 (ii) in subparagraph (B)(i)—

1 (I) by striking “2012, 2013, and
2 2014” and inserting “2017, 2018,
3 and 2019”; and

4 (II) by striking “2010 or 2011”
5 and inserting “2015 or 2016”; and

6 (C) in paragraph (5), by striking “2009”
7 and inserting “2014”;

8 (2) in subsection (b)(2)(A), in the matter pre-
9 ceding clause (i), by inserting “and youth at risk of
10 becoming victims of sex trafficking (as defined in
11 section 103(10) of the Trafficking Victims Protec-
12 tion Act of 2000 (22 U.S.C. 7102(10))) or victims
13 of a severe form of trafficking in persons described
14 in paragraph (9)(A) of that Act (22 U.S.C.
15 7102(9)(A))” after “adolescents”;

16 (3) in subsection(c)(1), by inserting “youth at
17 risk of becoming victims of sex trafficking (as de-
18 fined in section 103(10) of the Trafficking Victims
19 Protection Act of 2000 (22 U.S.C. 7102(10))) or
20 victims of a severe form of trafficking in persons de-
21 scribed in paragraph (9)(A) of that Act (22 U.S.C.
22 7102(9)(A)),” after “youth in foster care,”; and

23 (4) in subsection (f), by striking “2010 through
24 2014” and inserting “2015 through 2019”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall take effect on October 1, 2014.

3 **SEC. 223. FAMILY-TO-FAMILY HEALTH INFORMATION CEN-**
4 **TERS.**

5 (a) IN GENERAL.—Section 501(c) of the Social Secu-
6 rity Act (42 U.S.C. 701(c)) is amended—

7 (1) in paragraph (1)(A)—

8 (A) in clause (ii), by striking “and” after
9 the semicolon;

10 (B) in clause (iii), by striking the period
11 and inserting “; and”; and

12 (C) by adding at the end the following:

13 “(iv) \$6,000,000 for each of fiscal
14 years 2014 through 2018.”; and

15 (2) by striking paragraph (5).

16 (b) EFFECTIVE DATE.—The amendments made by
17 this section shall take effect as if enacted on October 1,
18 2013.

19 **SEC. 224. HEALTH WORKFORCE DEMONSTRATION PROJECT**
20 **FOR LOW-INCOME INDIVIDUALS.**

21 Section 2008(c)(1) of the Social Security Act (42
22 U.S.C. 1397g(c)(1)) is amended by striking “ through
23 2014” and inserting “2012, and only to carry out sub-
24 section (a), \$85,000,000 for each of fiscal years 2013
25 through 2016”.

1 **Subtitle D—Program Integrity**

2 **SEC. 231. REDUCING IMPROPER MEDICARE PAYMENTS.**

3 (a) MEDICARE ADMINISTRATIVE CONTRACTOR IM-
4 PROPER PAYMENT OUTREACH AND EDUCATION PRO-
5 GRAM.—

6 (1) IN GENERAL.—Section 1874A of the Social
7 Security Act (42 U.S.C. 1395kk–1) is amended—

8 (A) in subsection (a)(4)—

9 (i) by redesignating subparagraph (G)
10 as subparagraph (H); and

11 (ii) by inserting after subparagraph
12 (F) the following new subparagraph:

13 “(G) IMPROPER PAYMENT OUTREACH AND
14 EDUCATION PROGRAM.—Having in place an im-
15 proper payment outreach and education pro-
16 gram described in subsection (h).”;

17 (B) by adding at the end the following new
18 subsection:

19 “(h) IMPROPER PAYMENT OUTREACH AND EDU-
20 CATION PROGRAM.—

21 “(1) IN GENERAL.—In order to reduce im-
22 proper payments under this title, each medicare ad-
23 ministrative contractor shall establish and have in
24 place an improper payment outreach and education
25 program under which the contractor, through out-

1 reach, education, training, and technical assistance
2 activities, shall provide providers of services and sup-
3 pliers located in the region covered by the contract
4 under this section with the information described in
5 paragraph (3). The activities described in the pre-
6 ceding sentence shall be conducted on a regular
7 basis.

8 “(2) FORMS OF OUTREACH, EDUCATION, TRAIN-
9 ING, AND TECHNICAL ASSISTANCE ACTIVITIES.—The
10 outreach, education, training, and technical assist-
11 ance activities under a payment outreach and edu-
12 cation program shall be carried out through any of
13 the following:

14 “(A) Emails and other electronic commu-
15 nications.

16 “(B) Webinars.

17 “(C) Telephone calls.

18 “(D) In-person training.

19 “(E) Other forms of communications de-
20 termined appropriate by the Secretary.

21 “(3) INFORMATION TO BE PROVIDED THROUGH
22 ACTIVITIES.—The information to be provided to pro-
23 viders of services and suppliers under a payment
24 outreach and education program shall include all of
25 the following information:

1 “(A) A list of the provider’s or supplier’s
2 most frequent and expensive payment errors
3 over the last quarter.

4 “(B) Specific instructions regarding how to
5 correct or avoid such errors in the future.

6 “(C) A notice of all new topics that have
7 been approved by the Secretary for audits con-
8 ducted by recovery audit contractors under sec-
9 tion 1893(h).

10 “(D) Specific instructions to prevent fu-
11 ture issues related to such new audits.

12 “(E) Other information determined appro-
13 priate by the Secretary.

14 “(4) ERROR RATE REDUCTION TRAINING.—

15 “(A) IN GENERAL.—The activities under a
16 payment outreach and education program shall
17 include error rate reduction training.

18 “(B) REQUIREMENTS.—

19 “(i) IN GENERAL.—The training de-
20 scribed in subparagraph (A) shall—

21 “(I) be provided at least annu-
22 ally; and

23 “(II) focus on reducing the im-
24 proper payments described in para-
25 graph (5).

1 “(C) INVITATION.—A medicare adminis-
2 trative contractor shall ensure that all providers
3 of services and suppliers located in the region
4 covered by the contract under this section are
5 invited to attend the training described in sub-
6 paragraph (A) either in person or online.

7 “(5) PRIORITY.—A medicare administrative
8 contractor shall give priority to activities under the
9 improper payment outreach and education program
10 that will reduce improper payments for items and
11 services that—

12 “(A) have the highest rate of improper
13 payment;

14 “(B) have the greatest total dollar amount
15 of improper payments;

16 “(C) are due to clear misapplication or
17 misinterpretation of Medicare policies;

18 “(D) are clearly due to common and inad-
19 vertent clerical or administrative errors; or

20 “(E) are due to other types of errors that
21 the Secretary determines could be prevented
22 through activities under the program.

23 “(6) INFORMATION ON IMPROPER PAYMENTS
24 FROM RECOVERY AUDIT CONTRACTORS.—

1 “(A) IN GENERAL.—In order to assist
2 medicare administrative contractors in carrying
3 out improper payment outreach and education
4 programs, the Secretary shall provide each con-
5 tractor with a complete list of improper pay-
6 ments identified by recovery audit contractors
7 under section 1893(h) with respect to providers
8 of services and suppliers located in the region
9 covered by the contract under this section. Such
10 information shall be provided on a quarterly
11 basis.

12 “(B) INFORMATION.—The information de-
13 scribed in subparagraph (A) shall include the
14 following information:

15 “(i) The providers of services and
16 suppliers that have the highest rate of im-
17 proper payments.

18 “(ii) The providers of services and
19 suppliers that have the greatest total dollar
20 amounts of improper payments.

21 “(iii) The items and services furnished
22 in the region that have the highest rates of
23 improper payments.

24 “(iv) The items and services furnished
25 in the region that are responsible for the

1 greatest total dollar amount of improper
2 payments.

3 “(v) Other information the Secretary
4 determines would assist the contractor in
5 carrying out the improper payment out-
6 reach and education program.

7 “(C) FORMAT OF INFORMATION.—The in-
8 formation furnished to medicare administrative
9 contractors by the Secretary under this para-
10 graph shall be transmitted in a manner that
11 permits the contractor to easily identify the
12 areas of the Medicare program in which tar-
13 geted outreach, education, training, and tech-
14 nical assistance would be most effective. In car-
15 rying out the preceding sentence, the Secretary
16 shall ensure that—

17 “(i) the information with respect to
18 improper payments made to a provider of
19 services or supplier clearly displays the
20 name and address of the provider or sup-
21 plier, the amount of the improper payment,
22 and any other information the Secretary
23 determines appropriate; and

24 “(ii) the information is in an elec-
25 tronic, easily searchable database.

1 “(7) COMMUNICATIONS.—All communications
2 with providers of services and suppliers under a pay-
3 ment outreach and education program are subject to
4 the standards and requirements of subsection (g).

5 “(8) FUNDING.—After application of paragraph
6 (1)(C) of section 1893(h), the Secretary shall retain
7 a portion of the amounts recovered by recovery audit
8 contractors under such section which shall be avail-
9 able to the program management account of the
10 Centers for Medicare & Medicaid Services for pur-
11 poses of carrying out this subsection and to imple-
12 ment corrective actions to help reduce the error rate
13 of payments under this title. The amount retained
14 under the preceding sentence shall not exceed an
15 amount equal to 25 percent of the amounts recov-
16 ered under section 1893(h).”.

17 (2) FUNDING CONFORMING AMENDMENT.—Sec-
18 tion 1893(h)(2) of the Social Security Act (42
19 U.S.C. 1395ddd(h)(2)) is amended by inserting “or
20 section 1874(h)(8)” after “paragraph (1)(C)”.

21 (3) EFFECTIVE DATE.—The amendments made
22 by this subsection take effect on January 1, 2015.

23 (b) TRANSPARENCY.—Section 1893(h)(8) of the So-
24 cial Security Act (42 U.S.C. 1395ddd(h)(8)) is amended—

1 (1) by striking “REPORT.—The Secretary” and
2 inserting “REPORT.—

3 “(A) IN GENERAL.—The Secretary”; and

4 (2) by adding at the end the following new sub-
5 paragraph:

6 “(B) INCLUSION OF CERTAIN INFORMA-
7 TION.—

8 “(i) IN GENERAL.—For reports sub-
9 mitted under this paragraph for 2015 or a
10 subsequent year, each such report shall in-
11 clude the information described in clause
12 (ii) with respect to each of the following
13 categories of audits carried out by recovery
14 audit contractors under this subsection:

15 “(I) Automated.

16 “(II) Complex.

17 “(III) Medical necessity review.

18 “(IV) Part A.

19 “(V) Part B.

20 “(VI) Durable medical equip-
21 ment.

22 “(ii) INFORMATION DESCRIBED.—For
23 purposes of clause (i), the information de-
24 scribed in this clause, with respect to a
25 category of audit described in clause (i), is

1 the result of all appeals for each individual
2 level of appeals in such category.”.

3 (c) RECOVERY AUDIT CONTRACTOR DEMONSTRA-
4 TION PROJECT.—

5 (1) IN GENERAL.—The Secretary shall conduct
6 a demonstration project under title XVIII of the So-
7 cial Security Act that—

8 (A) targets audits by recovery audit con-
9 tractors under section 1893(h) of the Social Se-
10 curity Act (42 U.S.C. 1395ddd(h)) with respect
11 to high error providers of services and suppliers
12 identified under paragraph (3); and

13 (B) rewards low error providers of services
14 and suppliers identified under such paragraph.

15 (2) SCOPE.—

16 (A) DURATION.—The demonstration
17 project shall be implemented not later than
18 January 1, 2015, and shall be conducted for a
19 period of three years.

20 (B) DEMONSTRATION AREA.—In deter-
21 mining the geographic area of the demonstra-
22 tion project, the Secretary shall consider the
23 following:

24 (i) The total number of providers of
25 services and suppliers in the region.

1 (ii) The diversity of types of providers
2 of services and suppliers in the region.

3 (iii) The level and variation of im-
4 proper payment rates of and among indi-
5 vidual providers of services and suppliers
6 in the region.

7 (iv) The inclusion of a mix of both
8 urban and rural areas.

9 (3) IDENTIFICATION OF LOW ERROR AND HIGH
10 ERROR PROVIDERS OF SERVICES AND SUPPLIERS.—

11 (A) IN GENERAL.—In conducting the dem-
12 onstration project, the Secretary shall identify
13 the following two groups of providers in accord-
14 ance with this paragraph:

15 (i) Low error providers of services and
16 suppliers.

17 (ii) High error providers of services
18 and suppliers.

19 (B) ANALYSIS.—For purposes of identi-
20 fying the groups under subparagraph (A), the
21 Secretary shall analyze the following as they re-
22 late to the total number and amount of claims
23 submitted in the area and by each provider:

24 (i) The improper payment rates of in-
25 dividual providers of services and suppliers.

1 (ii) The amount of improper payments
2 made to individual providers of services
3 and suppliers.

4 (iii) The frequency of errors made by
5 the provider of services or supplier over
6 time.

7 (iv) Other information determined ap-
8 propriate by the Secretary.

9 (C) ASSIGNMENT BASED ON COMPOSITE
10 SCORE.—The Secretary shall assign selected
11 providers of services and suppliers under the
12 demonstration program based on a composite
13 score determined using the analysis under sub-
14 paragraph (B) as follows:

15 (i) Providers of services and suppliers
16 with high, expensive, and frequent errors
17 shall receive a high score and be identified
18 as high error providers of services and sup-
19 pliers under subparagraph (A).

20 (ii) Providers of services and suppliers
21 with few, inexpensive, and infrequent er-
22 rors shall receive a low score and be identi-
23 fied as low error providers of services and
24 suppliers under such subparagraph.

1 (iii) Only a small proportion of the
2 total providers of services and suppliers
3 and individual types of providers of serv-
4 ices and suppliers in the geographic area
5 of the demonstration project shall be as-
6 signed to either group identified under
7 such subparagraph.

8 (D) TIMEFRAME OF IDENTIFICATION.—

9 (i) IN GENERAL.—Any identification
10 of a provider of services or a supplier
11 under subparagraph (A) shall be for a pe-
12 riod of 12 months.

13 (ii) REEVALUATION.—The Secretary
14 shall reevaluate each such identification at
15 the end of such period.

16 (iii) USE OF MOST CURRENT INFOR-
17 MATION.—In carrying out the reevaluation
18 under clause (ii) with respect to a provider
19 of services or supplier, the Secretary
20 shall—

21 (I) consider the most current in-
22 formation available with respect to the
23 provider of services or supplier under
24 the analysis under subparagraph (B);
25 and

1 (II) take into account improve-
2 ment or regression of the provider of
3 services or supplier.

4 (4) ADJUSTMENT OF RECORD REQUEST MAX-
5 IMUM.—Under the demonstration project, the Sec-
6 retary shall establish procedures to—

7 (A) increase the maximum record request
8 made by recovery audit contractors to providers
9 of services and suppliers identified as high error
10 providers of services and suppliers under para-
11 graph (3); and

12 (B) decrease the maximum record request
13 made by recovery audit contractors to providers
14 of services and suppliers identified as low error
15 providers of services and supplier under such
16 paragraph.

17 (5) ADDITIONAL ADJUSTMENTS.—

18 (A) IN GENERAL.—Under the demonstra-
19 tion project, the Secretary may make additional
20 adjustments to requirements for recovery audit
21 contractors under section 1893(h) of the Social
22 Security Act (42 U.S.C. 1395ddd(h)) and the
23 conduct of audits with respect to low error pro-
24 viders of services and suppliers identified under
25 paragraph (3) and high error providers of serv-

1 ices and suppliers identified under such para-
2 graph as the Secretary determines necessary in
3 order to incentivize reductions in improper pay-
4 ment rates under title XVIII of such Act (42
5 U.S.C. 1395 et seq.).

6 (B) LIMITATION.—The Secretary shall not
7 exempt any group of providers of services or
8 suppliers in the demonstration project from
9 being subject to audit by a recovery audit con-
10 tractor under such section 1893(h).

11 (6) EVALUATION AND REPORT.—

12 (A) EVALUATION.—The Inspector General
13 of the Department of Health and Human Serv-
14 ices shall conduct an evaluation of the dem-
15 onstration project under this subsection. The
16 evaluation shall include an analysis of—

17 (i) the error rates of providers of serv-
18 ices and suppliers—

19 (I) identified under paragraph
20 (3) as low error providers of services
21 and suppliers;

22 (II) identified under such para-
23 graph as high error providers of serv-
24 ices and suppliers; and

1 (III) that are located in the geo-
2 graphic area of the demonstration
3 project and are not identified as either
4 a low error or high error provider of
5 services or supplier under such para-
6 graph; and

7 (ii) any improvements in the error
8 rates of those high error providers of serv-
9 ices and suppliers identified under such
10 paragraph.

11 (B) REPORT.—Not later than 12 months
12 after completion of the demonstration project,
13 the Inspector General shall submit to Congress
14 a report containing the results of the evaluation
15 conducted under subparagraph (A), together
16 with recommendations on whether the dem-
17 onstration project should be continued or ex-
18 panded, including on a permanent or nation-
19 wide basis.

20 (7) FUNDING.—

21 (A) FUNDING FOR IMPLEMENTATION.—
22 For purposes of carrying out the demonstration
23 project under this subsection (other than the
24 evaluation and report under paragraph (6)), the
25 Secretary shall provide for the transfer, from

1 the Federal Hospital Insurance Trust Fund
2 under section 1817 (42 U.S.C. 1395i) and the
3 Federal Supplementary Medical Insurance
4 Trust Fund under section 1841 (42 U.S.C.
5 1395t), in such proportion as the Secretary de-
6 termines appropriate, of \$10,000,000 to the
7 Centers for Medicare & Medicaid Services Pro-
8 gram Management Account.

9 (B) FUNDING FOR INSPECTOR GENERAL
10 EVALUATION AND REPORT.—For purposes of
11 carrying out the evaluation and report under
12 paragraph (6), the Secretary shall provide for
13 the transfer, from the Federal Hospital Insur-
14 ance Trust Fund under such section 1817 and
15 the Federal Supplementary Medical Insurance
16 Trust Fund under such section 1841, in such
17 proportion as the Secretary determines appro-
18 priate, of \$245,000 to the Inspector General of
19 the Department of Health and Human Services.

20 (C) AVAILABILITY.—Amounts transferred
21 under subparagraph (A) or (B) shall remain
22 available until expended.

23 (8) DEFINITIONS.—In this section:

1 (A) DEMONSTRATION PROJECT.—The term
2 “demonstration project” means the demonstra-
3 tion project under this subsection.

4 (B) PROVIDER OF SERVICES.—The term
5 “provider of services” has the meaning given
6 that term in section 1861(u).

7 (C) RECOVERY AUDIT CONTRACTOR.—The
8 term “recovery audit contractor” means an en-
9 tity with a contract under section 1893(h) of
10 the Social Security Act (42 U.S.C.
11 1395ddd(h)).

12 (D) SECRETARY.—The term “Secretary”
13 means the Secretary of Health and Human
14 Services.

15 (E) SUPPLIER.—The term “supplier” has
16 the meaning given that term in section 1861(d).

17 **SEC. 232. AUTHORITY FOR MEDICAID FRAUD CONTROL**
18 **UNITS TO INVESTIGATE AND PROSECUTE**
19 **COMPLAINTS OF ABUSE AND NEGLECT OF**
20 **MEDICAID PATIENTS IN HOME AND COMMU-**
21 **NITY-BASED SETTINGS.**

22 (a) IN GENERAL.—Section 1903(q)(4)(A) of the So-
23 cial Security Act (42 U.S.C. 1396b(q)(4)(A)) is amended
24 to read as follows:

1 “(4)(A) The entity’s function includes a state-
2 wide program for the—

3 “(i) investigation and prosecution, or refer-
4 ral for prosecution or other action, of com-
5 plaints of abuse or neglect of patients in health
6 care facilities which receive payments under the
7 State plan under this title or under a waiver of
8 such plan;

9 “(ii) at the option of the entity, investiga-
10 tion and prosecution, or referral for prosecution
11 or other action, of complaints of abuse or ne-
12 glect of individuals in connection with any as-
13 pect of the provision of medical assistance and
14 the activities of providers of such assistance in
15 a home or community based setting that is paid
16 for under the State plan under this title or
17 under a waiver of such plan; and

18 “(iii) at the option of the entity, investiga-
19 tion and prosecution, or referral for prosecution
20 or other action, of complaints of abuse or ne-
21 glect of patients residing in board and care fa-
22 cilities.”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a) shall take effect on January 1, 2015.

1 **SEC. 233. IMPROVED USE OF FUNDS RECEIVED BY THE HHS**
2 **INSPECTOR GENERAL FROM OVERSIGHT AND**
3 **INVESTIGATIVE ACTIVITIES.**

4 (a) IN GENERAL.—Section 1128C(b) of the Social
5 Security Act (42 U.S.C. 1320a–7c(b)) is amended to read
6 as follows:

7 “(b) ADDITIONAL USE OF FUNDS BY INSPECTOR
8 GENERAL.—

9 “(1) COLLECTIONS FROM MEDICARE AND MED-
10 ICAID RECOVERY ACTIONS.—Notwithstanding section
11 3302 of title 31, United States Code, or any other
12 provision of law affecting the crediting of collections,
13 the Inspector General of the Department of Health
14 and Human Services may receive and retain three
15 percent of all amounts collected pursuant to civil
16 debt collection actions related to false claims or
17 frauds involving the Medicare program under title
18 XVIII or the Medicaid program under title XIX.

19 “(2) CREDITING.—Funds received by the In-
20 spector General under paragraph (1) shall be depos-
21 ited to the credit of any appropriation available for
22 oversight and enforcement activities of the Inspector
23 General permitted under subsection (a), and shall
24 remain available until expended.”.

25 (b) EFFECTIVE DATE.—The amendment made by
26 subsection (a) shall apply to funds received from settle-

1 ments finalized, or judgements entered, on or after the
2 date of the enactment of this Act.

3 **SEC. 234. PREVENTING AND REDUCING IMPROPER MEDI-**
4 **CARE AND MEDICAID EXPENDITURES.**

5 (a) **REQUIRING VALID PRESCRIBER NATIONAL PRO-**
6 **VIDER IDENTIFIERS ON PHARMACY CLAIMS.**—Section
7 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–
8 104(e)) is amended by adding at the end the following new
9 paragraph:

10 “(4) **REQUIRING VALID PRESCRIBER NATIONAL**
11 **PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.**—

12 “(A) **IN GENERAL.**—For plan year 2015
13 and subsequent plan years, subject to subpara-
14 graph (B), the Secretary shall prohibit PDP
15 sponsors of prescription drug plans from paying
16 claims for prescription drugs under this part
17 that do not include a valid prescriber National
18 Provider Identifier.

19 “(B) **PROCEDURES.**—The Secretary shall
20 establish procedures for determining the validity
21 of prescriber National Provider Identifiers
22 under subparagraph (A).

23 “(C) **REPORT.**—Not later than January 1,
24 2017, the Inspector General of the Department
25 of Health and Human Services shall submit to

1 Congress a report on the effectiveness of the
2 procedures established under subparagraph
3 (B).”.

4 (b) REFORMING HOW CMS TRACKS AND CORRECTS
5 THE VULNERABILITIES IDENTIFIED BY RECOVERY AUDIT
6 CONTRACTORS.—Section 1893(h) of the Social Security
7 Act (42 U.S.C. 1395ddd(h)) is amended—

8 (1) in paragraph (8), as amended by section
9 231, by adding at the end the following new sub-
10 paragraphs:

11 “(C) INCLUSION OF IMPROPER PAYMENT
12 VULNERABILITIES IDENTIFIED.—For reports
13 submitted under this paragraph for 2015 or a
14 subsequent year, each such report shall in-
15 clude—

16 “(i) a description of—

17 “(I) the types and financial cost
18 to the program under this title of im-
19 proper payment vulnerabilities identi-
20 fied by recovery audit contractors
21 under this subsection; and

22 “(II) how the Secretary is ad-
23 dressing such improper payment
24 vulnerabilities; and

1 “(ii) an assessment of the effective-
2 ness of changes made to payment policies
3 and procedures under this title in order to
4 address the vulnerabilities so identified.

5 “(D) LIMITATION.—The Secretary shall
6 ensure that each report submitted under sub-
7 paragraph (A) does not include information
8 that the Secretary determines would be sen-
9 sitive or would otherwise negatively impact pro-
10 gram integrity.”; and

11 (2) by adding at the end the following new
12 paragraph:

13 “(10) ADDRESSING IMPROPER PAYMENT
14 VULNERABILITIES.—The Secretary shall address im-
15 proper payment vulnerabilities identified by recovery
16 audit contractors under this subsection in a timely
17 manner, prioritized based on the risk to the program
18 under this title.”.

19 (c) STRENGTHENING MEDICAID PROGRAM INTEG-
20 RITY THROUGH FLEXIBILITY.—Section 1936 of the Social
21 Security Act (42 U.S.C. 1396u–6) is amended—

22 (1) in subsection (a), by inserting “, or other-
23 wise,” after “entities”; and

24 (2) in subsection (e)—

1 (A) in paragraph (1), in the matter pre-
2 ceeding subparagraph (A), by inserting “(includ-
3 ing the costs of equipment, salaries and bene-
4 fits, and travel and training)” after “Program
5 under this section”; and

6 (B) in paragraph (3), by striking “by 100”
7 and inserting “by 100, or such number as de-
8 termined necessary by the Secretary to carry
9 out the Program under this section,”.

10 (d) ACCESS TO THE NATIONAL DIRECTORY OF NEW
11 HIRES.—Section 453(j) of the Social Security Act (42
12 U.S.C. 653(j)) is amended by adding at the end the fol-
13 lowing new paragraph:

14 “(12) INFORMATION COMPARISONS AND DIS-
15 CLOSURES TO ASSIST IN ADMINISTRATION OF THE
16 MEDICARE PROGRAM AND STATE HEALTH SUBSIDY
17 PROGRAMS.—

18 “(A) DISCLOSURE TO THE ADMINIS-
19 TRATOR OF THE CENTERS FOR MEDICARE &
20 MEDICAID SERVICES.—The Administrator of
21 the Centers for Medicare & Medicaid shall have
22 access to the information in the National Direc-
23 tory of New Hires for purposes of determining
24 the eligibility of an applicant for, or enrollee in,
25 the Medicare program under title XVIII or an

1 applicable State health subsidy program (as de-
2 fined in section 1413(e) of the Patient Protec-
3 tion and Affordable Care Act (42 U.S.C.
4 18083(e)).

5 “(B) DISCLOSURE TO THE INSPECTOR
6 GENERAL OF THE DEPARTMENT OF HEALTH
7 AND HUMAN SERVICES.—

8 “(i) IN GENERAL.—If the Inspector
9 General of the Department of Health and
10 Human Services transmits to the Secretary
11 the names and social security account
12 numbers of individuals, the Secretary shall
13 disclose to the Inspector General informa-
14 tion on such individuals and their employ-
15 ers maintained in the National Directory
16 of New Hires.

17 “(ii) USE OF INFORMATION.—The In-
18 spector General of the Department of
19 Health and Human Services may use in-
20 formation provided under clause (i) only
21 for purposes of —

22 “(I) determining the eligibility of
23 an applicant for, or enrollee in, the
24 Medicare program under title XVIII
25 or an applicable State health subsidy

1 program (as defined in section
2 1413(e) of the Patient Protection and
3 Affordable Care Act (42 U.S.C.
4 18083(e)); or

5 “(II) evaluating the integrity of
6 the Medicare program or an applica-
7 ble State health subsidy program (as
8 so defined).

9 “(C) DISCLOSURE TO STATE AGENCIES.—

10 “(i) IN GENERAL.—If, for purposes of
11 determining the eligibility of an applicant
12 for, or an enrollee in, an applicable State
13 health subsidy program (as defined in sec-
14 tion 1413(e) of the Patient Protection and
15 Affordable Care Act (42 U.S.C. 18083(e)),
16 a State agency responsible for admin-
17 istering such program transmits to the
18 Secretary the names, dates of birth, and
19 social security account numbers of individ-
20 uals, the Secretary shall disclose to such
21 State agency information on such individ-
22 uals and their employers maintained in the
23 National Directory of New Hires, subject
24 to this subparagraph.

1 “(ii) CONDITION ON DISCLOSURE BY
2 THE SECRETARY.—The Secretary shall
3 make a disclosure under clause (i) only to
4 the extent that the Secretary determines
5 that the disclosure would not interfere with
6 the effective operation of the program
7 under this part.

8 “(iii) USE AND DISCLOSURE OF IN-
9 FORMATION BY STATE AGENCIES.—

10 “(I) IN GENERAL.—A State
11 agency may not use or disclose infor-
12 mation provided under clause (i) ex-
13 cept for purposes of determining the
14 eligibility of an applicant for, or an
15 enrollee in, a program referred to in
16 clause (i).

17 “(II) INFORMATION SECURITY.—
18 The State agency shall have in effect
19 data security and control policies that
20 the Secretary finds adequate to ensure
21 the security of information obtained
22 under clause (i) and to ensure that
23 access to such information is re-
24 stricted to authorized persons for pur-

1 poses of authorized uses and dislo-
2 sures.

3 “(III) PENALTY FOR MISUSE OF
4 INFORMATION.—An officer or em-
5 ployee of the State agency who fails to
6 comply with this clause shall be sub-
7 ject to the sanctions under subsection
8 (l)(2) to the same extent as if such of-
9 ficer or employee were an officer or
10 employee of the United States.

11 “(iv) PROCEDURAL REQUIREMENTS.—
12 State agencies requesting information
13 under clause (i) shall adhere to uniform
14 procedures established by the Secretary
15 governing information requests and data
16 matching under this paragraph.

17 “(v) REIMBURSEMENT OF COSTS.—
18 The State agency shall reimburse the Sec-
19 retary, in accordance with subsection
20 (k)(3), for the costs incurred by the Sec-
21 retary in furnishing the information re-
22 quested under this subparagraph.”.

23 (e) IMPROVING THE SHARING OF DATA BETWEEN
24 THE FEDERAL GOVERNMENT AND STATE MEDICAID PRO-
25 GRAMS.—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services (in this subsection referred to as
3 the “Secretary”) shall establish a plan to encourage
4 and facilitate the participation of States in the Medi-
5 care-Medicaid Data Match Program (commonly re-
6 ferred to as the “Medi-Medi Program”) under sec-
7 tion 1893(g) of the Social Security Act (42 U.S.C.
8 1395ddd(g)).

9 (2) PROGRAM REVISIONS TO IMPROVE MEDI-
10 MEDI DATA MATCH PROGRAM PARTICIPATION BY
11 STATES.—Section 1893(g)(1)(A) of the Social Secu-
12 rity Act (42 U.S.C. 1395ddd(g)(1)(A)) is amend-
13 ed—

14 (A) in the matter preceding clause (i), by
15 inserting “or otherwise” after “eligible enti-
16 ties”;

17 (B) in clause (i)—

18 (i) by inserting “to review claims
19 data” after “algorithms”; and

20 (ii) by striking “service, time, or pa-
21 tient” and inserting “provider, service,
22 time, or patient”;

23 (C) in clause (ii)—

1 (i) by inserting “to investigate and re-
2 cover amounts with respect to suspect
3 claims” after “appropriate actions”; and

4 (ii) by striking “; and” and inserting
5 a semicolon;

6 (D) in clause (iii), by striking the period
7 and inserting “; and”; and

8 (E) by adding at end the following new
9 clause:

10 “(iv) furthering the Secretary’s de-
11 sign, development, installation, or enhance-
12 ment of an automated data system archi-
13 tecture—

14 “(I) to collect, integrate, and as-
15 sess data for purposes of program in-
16 tegrity, program oversight, and ad-
17 ministration, including the Medi-Medi
18 Program; and

19 “(II) that improves the coordina-
20 tion of requests for data from
21 States.”.

22 (3) PROVIDING STATES WITH DATA ON IM-
23 PROPER PAYMENTS MADE FOR ITEMS OR SERVICES
24 PROVIDED TO DUAL ELIGIBLE INDIVIDUALS.—

1 (A) IN GENERAL.—The Secretary shall de-
 2 velop and implement a plan that allows each
 3 State agency responsible for administering a
 4 State plan for medical assistance under title
 5 XIX of the Social Security Act access to rel-
 6 evant data on improper or fraudulent payments
 7 made under the Medicare program under title
 8 XVIII of the Social Security Act (42 U.S.C.
 9 1395 et seq.) for health care items or services
 10 provided to dual eligible individuals.

11 (B) DUAL ELIGIBLE INDIVIDUAL DE-
 12 FINED.—In this paragraph, the term “dual eli-
 13 gible individual” means an individual who is en-
 14 titled to, or enrolled for, benefits under part A
 15 of title XVIII of the Social Security Act (42
 16 U.S.C. 1395c et seq.), or enrolled for benefits
 17 under part B of title XVIII of such Act (42
 18 U.S.C. 1395j et seq.), and is eligible for medical
 19 assistance under a State plan under title XIX
 20 of such Act (42 U.S.C. 1396 et seq.) or under
 21 a waiver of such plan.

22 **Subtitle E—Other Provisions**

23 **SEC. 241. COMMISSION ON IMPROVING PATIENT DIRECTED** 24 **HEALTH CARE.**

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

1 (1) In order to elevate the role of patient
2 choices in the health care system, the American pub-
3 lic must engage in an informed, national, public de-
4 bate on how the current health care system empow-
5 ers and informs health care decision-making, and
6 what can be done to improve the likelihood patients
7 receive the care they want and need.

8 (2) Research suggests that patients often do
9 not receive the care they want. As a result, the end
10 of life is associated with a substantial burden of suf-
11 fering by the patient and negative health and finan-
12 cial consequences that extend to family members and
13 society.

14 (3) Patients face a complex and fragmented
15 health care system that may decrease the likelihood
16 that health care choices are known and carried out.
17 The health care system should embed principles that
18 take into account patient wishes.

19 (4) Decisions concerning health care, including
20 end-of-life issues, affect an increasing number of
21 Americans.

22 (5) Medical advances are prolonging life expect-
23 ancy in the United States both in acute life-threat-
24 ening situations and protracted battles with illness.

1 These advances raise new challenges surrounding
2 health care decision-making.

3 (6) The United States health care system
4 should promote consideration of a person’s pref-
5 erence in health care decision-making and end-of-life
6 choices.

7 (b) COMMISSION.—The Social Security Act is amend-
8 ed by inserting after section 1150B (42 U.S.C. 1320b-
9 24) the following new section:

10 **“SEC. 1150C. COMMISSION ON IMPROVING PATIENT DI-**
11 **RECTED HEALTH CARE.**

12 “(a) PURPOSES.—The purposes of this section are
13 to—

14 “(1) provide a forum for a nationwide public
15 debate on improving patient self-determination in
16 health care decision-making;

17 “(2) identify strategies that ensure every Amer-
18 ican has the health care they want; and

19 “(3) provide recommendations to Congress that
20 result from the debate.

21 “(b) ESTABLISHMENT.—The Secretary shall estab-
22 lish an entity to be known as the Commission on Improv-
23 ing Patient Directed Health Care (referred to in this sec-
24 tion as the ‘Commission’).

25 “(c) MEMBERSHIP.—

1 “(1) NUMBER AND APPOINTMENT.—The Com-
2 mission shall be composed of 15 members. One
3 member shall be the Secretary. The Comptroller
4 General of the United States shall appoint 14 mem-
5 bers.

6 “(2) QUALIFICATIONS.—The membership of the
7 Commission shall include—

8 “(A) health care consumers impacted by
9 decision-making in advance of a health care cri-
10 sis, such as individuals of advanced age, indi-
11 viduals with chronic, terminal and mental ill-
12 nesses, family care givers, and individuals with
13 disabilities;

14 “(B) providers in settings where crucial
15 health care decision-making occurs, such as
16 those working in intensive care settings, emer-
17 gency room departments, primary care settings,
18 nursing homes, hospice, or palliative care set-
19 tings;

20 “(C) payors ensuring patients get the level
21 of care they want;

22 “(D) experts in advance care planning,
23 hospice, palliative care, information technology,
24 bioethics, aging policy, disability policy, pedi-

1 atric ethics, cultural sensitivity, psychology, and
2 health care financing;

3 “(E) individuals who represent culturally
4 diverse perspectives on patient self-determina-
5 tion and end-of-life issues; and

6 “(F) members of the faith community.

7 “(d) PERIOD OF APPOINTMENT.—Members of the
8 Commission shall be appointed for the life of the Commis-
9 sion. Any vacancies shall not affect the power and duties
10 of the Commission but shall be filled in the same manner
11 as the original appointment.

12 “(e) DESIGNATION OF THE CHAIRPERSON.—Not
13 later than 15 days after the date on which all members
14 of the Commission have been appointed, the Comptroller
15 General shall designate the chairperson of the Commis-
16 sion.

17 “(f) SUBCOMMITTEES.—The Commission may estab-
18 lish subcommittees if doing so increases the efficiency of
19 the Commission in completing tasks.

20 “(g) DUTIES.—

21 “(1) HEARINGS.—Not later than 90 days after
22 the date of designation of the chairperson under
23 subsection (e), the Commission shall hold no fewer
24 than 8 hearings to examine—

1 “(A) the current state of health care deci-
2 sion-making and advance care planning laws in
3 the United States at the Federal level and
4 across the States, as well as options for improv-
5 ing advance care planning tools, especially with
6 regard to use, portability, and storage;

7 “(B) consumer-focused approaches that
8 educate the American public about patient
9 choices, care planning, and other end-of-life
10 issues;

11 “(C) the use of comprehensive, patient-cen-
12 tered care plans by providers, the impact care
13 plans have on health care delivery, and methods
14 to expand the use of high quality care planning
15 tools in both public and private health care sys-
16 tems;

17 “(D) the role of electronic medical records
18 and other technologies in improving patient-di-
19 rected health care;

20 “(E) innovative tools for improving patient
21 experience with advanced illness, such as pallia-
22 tive care, hospice, and other models;

23 “(F) the role social determinants of health,
24 such as socio-economic status, play in patient
25 self-direction in health care;

1 “(G) the use of culturally-competent tools
2 for health care decision-making;

3 “(H) strategies for educating providers on
4 care planning, palliative care, hospice care, and
5 other issues surrounding honoring patient
6 choices;

7 “(I) the sociological and psychological fac-
8 tors that influence health care decision-making
9 and end-of-life choices; and

10 “(J) the role of spirituality and religion in
11 patient self-determination in health care.

12 “(2) ADDITIONAL HEARINGS.—The Commission
13 may hold additional hearings on subjects other than
14 those listed in paragraph (1) so long as such hear-
15 ings are determined necessary by the Commission in
16 carrying out the purposes of this section. Such addi-
17 tional hearings do not have to be completed within
18 the time period specified but shall not delay the
19 other activities of the Commission under this sec-
20 tion.

21 “(3) NUMBER AND LOCATION OF HEARINGS
22 AND ADDITIONAL HEARINGS.—The Commission shall
23 hold no fewer than 8 hearings as indicated in para-
24 graph (1) and in sufficient number in order to re-
25 ceive information that reflects—

1 “(A) the geographic differences throughout
2 the United States;

3 “(B) diverse populations; and

4 “(C) a balance among urban and rural
5 populations.

6 “(4) INTERACTIVE TECHNOLOGY.—The Com-
7 mission may encourage public participation in hear-
8 ings through interactive technology and other means
9 as determined appropriate by the Commission.

10 “(5) REPORT TO THE AMERICAN PEOPLE ON
11 PATIENT DIRECTED HEALTH CARE.—Not later than
12 90 days after the hearings described in paragraphs
13 (1) and (2) are completed, the Commission shall
14 prepare and make available to health care consumers
15 through the Internet and other appropriate public
16 channels, a report to be entitled, ‘Report to the
17 American People on Patient Directed Health Care’.
18 Such a report shall be understandable to the general
19 public and include—

20 “(A) a summary of—

21 “(i) the hearings described in such
22 paragraphs;

23 “(ii) how the current health care sys-
24 tem empowers and informs decision-mak-
25 ing in advance of a health care crisis;

1 “(iii) factors that contribute to the
2 provision of health care that does not ad-
3 here to patient wishes;

4 “(iv) the impact of care that does not
5 follow patient choices, particularly at the
6 end-of-life, on patients, families, providers,
7 and the health care system;

8 “(v) the laws surrounding advance
9 care planning and health care decision-
10 making including issues of portability, use,
11 and storage;

12 “(vi) consumer-focused approaches to
13 education of the American public about pa-
14 tient choices, care planning, and other end-
15 of-life issues;

16 “(vii) the role of care plans in health
17 care decision-making;

18 “(viii) the role of providers in ensur-
19 ing patients receive the care they want;

20 “(ix) the role of electronic medical
21 records and other technologies in improv-
22 ing patient directed health care;

23 “(x) the impact of social determinants
24 on patient self-direction in health care
25 services;

1 “(xi) the use of culturally competent
2 methods for health care decision-making;

3 “(xii) the sociological and psycho-
4 logical factors that influence patient self-
5 determination; and

6 “(xiii) the role of spirituality and reli-
7 gion in health care decision-making and
8 end-of-life care;

9 “(B) best practices from communities, pro-
10 viders, and payors that document patient wish-
11 es and provide health care that adheres to those
12 wishes; and

13 “(C) information on educating providers
14 about health care decision-making and end-of-
15 life issues.

16 “(6) INTERIM REQUIREMENTS.—Not later than
17 180 days after the date of completion of the hear-
18 ings, the Commission shall prepare and make avail-
19 able to the public through the Internet and other ap-
20 propriate public channels, an interim set of rec-
21 ommendations on patient self-determination in
22 health care and ways to improve and strengthen the
23 health care system based on the information and
24 preferences expressed at the community meetings.

1 There shall be a 90-day public comment period on
2 such recommendations.

3 “(h) RECOMMENDATIONS.—Not later than 120 days
4 after the expiration of the public comment period de-
5 scribed in subsection (g)(6), the Commission shall submit
6 to Congress and the President a final set of recommenda-
7 tions. The recommendations must be comprehensive and
8 detailed. The recommendations must contain rec-
9 ommendations or proposals for legislative or administra-
10 tive action as the Commission deems appropriate, includ-
11 ing proposed legislative language to carry out the rec-
12 ommendations or proposals.

13 “(i) ADMINISTRATION.—

14 “(1) EXECUTIVE DIRECTOR.—There shall be an
15 Executive Director of the Commission who shall be
16 appointed by the chairperson of the Commission in
17 consultation with the members of the Commission.

18 “(2) COMPENSATION.—While serving on the
19 business of the Commission (including travel time),
20 a member of the Commission shall be entitled to
21 compensation at the per diem equivalent of the rate
22 provided for level IV of the Executive Schedule
23 under section 5315 of title 5, United States Code,
24 and while so serving away from home and the mem-
25 ber’s regular place of business, a member may be al-

1 lowed travel expenses, as authorized by the chair-
2 person of the Commission. For purposes of pay and
3 employment benefits, rights, and privileges, all per-
4 sonnel of the Commission shall be treated as if they
5 were employees of the Senate.

6 “(3) INFORMATION FROM FEDERAL AGEN-
7 CIES.—The Commission may secure directly from
8 any Federal department or agency such information
9 as the Commission considers necessary to carry out
10 this section. Upon request of the Commission the
11 head of such department or agency shall furnish
12 such information.

13 “(4) POSTAL SERVICES.—The Commission may
14 use the United States mails in the same manner and
15 under the same conditions as other departments and
16 agencies of the Federal Government.

17 “(j) DETAIL.—Not more than 5 Federal Government
18 employees employed by the Department of Labor, 5 Fed-
19 eral Government employees employed by the Social Secu-
20 rity Administration, and 10 Federal Government employ-
21 ees employed by the Department of Health and Human
22 Services may be detailed to the Commission under this
23 section without further reimbursement. Any detail of an
24 employee shall be without interruption or loss of civil serv-
25 ice status or privilege.

1 “(k) TEMPORARY AND INTERMITTENT SERVICES.—

2 The chairperson of the Commission may procure tem-
3 porary and intermittent services under section 3109(b) of
4 title 5, United States Code, at rates for individuals which
5 do not exceed the daily equivalent of the annual rate of
6 basic pay prescribed for level V of the Executive Schedule
7 under section 5316 of such title.

8 “(l) ANNUAL REPORT.—Not later than 1 year after
9 the date of enactment of this Act, and annually thereafter
10 during the existence of the Commission, the Commission
11 shall report to Congress and make public a detailed de-
12 scription of the expenditures of the Commission used to
13 carry out its duties under this section.

14 “(m) SUNSET OF COMMISSION.—The Commission
15 shall terminate on the date that is 4 years after the date
16 on which all the members of the Commission have been
17 appointed under subsection (c)(1) and appropriations are
18 first made available to carry out this section.

19 “(n) ADMINISTRATION REVIEW AND COMMENTS.—
20 Not later than 45 days after receiving the final rec-
21 ommendations of the Commission under subsection (h),
22 the President shall submit a report to Congress which
23 shall contain—

24 “(1) additional views and comments on such
25 recommendations; and

1 “(2) recommendations for such legislation and
2 administrative action as the President considers ap-
3 propriate.

4 “(o) REQUIRED CONGRESSIONAL ACTION.—Not later
5 than 45 days after receiving the report submitted by the
6 President under subsection (n), each committee of juris-
7 diction of Congress, the Committee on Finance of the Sen-
8 ate, the Committee on Health, Education, Labor, and
9 Pensions of the Senate, the Committee on Ways and
10 Means of the House of Representatives, the Committee on
11 Energy and Commerce of the House of Representatives,
12 and the Committee on Education and the Workforce of
13 the House of Representatives, shall hold at least 1 hearing
14 on such report and on the final recommendations of the
15 Commission submitted under subsection (h).

16 “(p) AUTHORIZATION OF APPROPRIATIONS.—

17 “(1) IN GENERAL.—There are authorized to be
18 appropriated to carry out this section, \$3,000,000
19 for each of fiscal years 2014 and 2015.

20 “(2) REPORT TO THE AMERICAN PEOPLE ON
21 PATIENT DIRECTED HEALTH CARE.—There are au-
22 thorized to be appropriated for the preparation and
23 dissemination of the Report to the American People
24 on Patient Directed Health Care described in sub-
25 section (g)(5), such sums as may be necessary for

1 the fiscal year in which the report is required to be
2 submitted.”.

3 **SEC. 242. EXPANSION OF THE DEFINITION OF INPATIENT**
4 **HOSPITAL SERVICES FOR CERTAIN CANCER**
5 **HOSPITALS.**

6 Section 1861(b)(3) of the Social Security Act (42
7 U.S.C. 1395x(b)(3)) is amended—

8 (1) by inserting “(A)” after “(3)”; and

9 (2) by adding “and” after the semicolon at the
10 end; and

11 (3) by adding at the end the following new sub-
12 paragraph:

13 “(B) with respect to a hospital that is described
14 in section 1886(d)(1)(B)(v) and that, as of the date
15 of the enactment of the SGR Repeal and Medicare
16 Beneficiary Access Act of 2013, is located in the
17 same building, or on the same campus, as another
18 hospital, items and services described in paragraphs
19 (1) and (2) furnished on or after such date of enact-
20 ment by the hospital described in such section or by
21 others under arrangements with them made by the
22 hospital;”.

1 **SEC. 243. QUALITY MEASURES FOR CERTAIN POST-ACUTE**
2 **CARE PROVIDERS RELATING TO NOTICE AND**
3 **TRANSFER OF PATIENT HEALTH INFORMA-**
4 **TION AND PATIENT CARE PREFERENCES.**

5 (a) DEVELOPMENT.—The Secretary of Health and
6 Human Services (in this section referred to as the “Sec-
7 retary”) shall provide for the development of one or more
8 quality measures under title XVIII of the Social Security
9 Act (42 U.S.C. 1395 et seq.) to accurately communicate
10 the existence and provide for the transfer of patient health
11 information and patient care preferences when an indi-
12 vidual transitions from a hospital to return home or move
13 to other post-acute care settings.

14 (b) USE OF MEASURE DEVELOPERS.—The Secretary
15 shall arrange for the development of such measures by ap-
16 propriate measure developers.

17 (c) ENDORSEMENT.—The Secretary shall arrange for
18 such developed measures to be submitted for endorsement
19 to a consensus-based entity as described in section
20 1890(a) of the Social Security Act (42 U.S.C.
21 1395aaa(a)), as amended by section 208.

22 (d) USE OF MEASURES.—The Secretary shall,
23 through notice and comment rulemaking, use such meas-
24 ures under the quality reporting programs with respect
25 to—

1 (1) inpatient hospitals under section
2 1886(b)(3)(B)(viii) of the Social Security Act (42
3 U.S.C. 1395ww(b)(3)(B)(viii));

4 (2) skilled nursing facilities under section
5 1888(e) of such Act (42 U.S.C. 1395yy(e));

6 (3) home health services under section
7 1895(b)(3)(B)(v) of such Act (42 U.S.C.
8 1395fff(b)(3)(B)(v)); and

9 (4) other providers of services (as defined in
10 section 1861(u) of such Act) and suppliers (as de-
11 fined in section 1861(d) of such Act) that the Sec-
12 retary determines appropriate.

13 **SEC. 244. CRITERIA FOR MEDICALLY NECESSARY, SHORT**
14 **INPATIENT HOSPITAL STAYS.**

15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services shall consult with, and seek input from,
17 interested stakeholders to determine appropriate criteria
18 for payment under the Medicare program under title VIII
19 of the Social Security Act of an inpatient hospital admis-
20 sion that—

21 (1) is medically necessary; and

22 (2) is an inpatient hospital stay that is less
23 than two midnights, as described in section 412.3 of
24 title 42, Code of Federal Regulation, as finalized in
25 the final rule published by the Centers for Medicare

1 & Medicaid Services in the Federal Register on Au-
2 gust 19, 2013 (78 Federal Register 50496) entitled
3 “Medicare Program; Hospital Inpatient Prospective
4 Payment Systems for Acute Care Hospitals and the
5 Long-Term Care Hospital Prospective Payment Sys-
6 tem and Fiscal Year 2014 Rates; Quality Reporting
7 Requirements for Specific Providers; Hospital Con-
8 ditions of Participation; Payment Policies Related to
9 Patient Status”.

10 (b) INTERESTED STAKEHOLDERS.—In subsection
11 (a), the term “interested stakeholders” means the fol-
12 lowing:

13 (1) Hospitals.

14 (2) Physicians

15 (3) Medicare administrative contractors under
16 section 1874A of the Social Security Act (42 U.S.C.
17 1395kk–1).

18 (4) Recovery audit contractors under section
19 1893(h) of such Act (42 U.S.C. 1395ddd(h)).

20 (5) Other parties determined appropriate by the
21 Secretary.

1 **SEC. 245. TRANSPARENCY OF REASONS FOR EXCLUDING**
2 **ADDITIONAL PROCEDURES FROM THE MEDI-**
3 **CARE AMBULATORY SURGICAL CENTER (ASC)**
4 **APPROVED LIST.**

5 Section 1833(i)(1) of the Social Security Act (42
6 U.S.C. 1395l(i)(1)) is amended by adding at the end the
7 following: “In updating such lists for application in years
8 beginning after December 31, 2014, for each procedure
9 that was requested to be included on such lists during the
10 public comment period but which the Secretary does not
11 propose (in the final rule updating such lists) to so in-
12 clude, the Secretary shall describe in such final rule the
13 specific safety criteria for not including such procedure on
14 such lists.”.

15 **SEC. 246. SUPERVISION IN CRITICAL ACCESS HOSPITALS.**

16 (a) **GENERAL SUPERVISION IN CRITICAL ACCESS**
17 **HOSPITALS.**—Section 1834(g) of the Social Security Act
18 (42 U.S.C. 1395m(g)) is amended by adding at the end
19 the following new paragraph:

20 “(6) **SUPERVISION.**—In the case of services fur-
21 nished on or after the date of the enactment of this
22 paragraph, the level of supervision with respect to
23 outpatient critical access hospital services shall be
24 general supervision (as defined by the Secretary).”.

25 (b) **SUPERVISION OF CARDIAC AND PULMONARY RE-**
26 **HABILITATION PROGRAMS IN CRITICAL ACCESS HOS-**

1 PITALS.—Section 1861(eee)(2)(B) of the Social Security
 2 Act (42 U.S.C. 1395x(eee)(2)(B)) is amended by inserting
 3 “, or in the case of a critical access hospital, a physician,
 4 or (beginning on the date of enactment of the SGR Repeal
 5 and Medicare Beneficiary Access Act of 2013) a nurse
 6 practitioner, clinical nurse specialist, or physician assist-
 7 ant (as such terms are defined in subsection (aa)(5)),”
 8 after “a physician”.

9 **SEC. 247. REQUIRING STATE LICENSURE OF BIDDING ENTI-**
 10 **TIES UNDER THE COMPETITIVE ACQUISITION**
 11 **PROGRAM FOR CERTAIN DURABLE MEDICAL**
 12 **EQUIPMENT, PROSTHETICS, ORTHOTICS, AND**
 13 **SUPPLIES (DMEPOS).**

14 Section 1847(a)(1) of the Social Security Act (42
 15 U.S.C. 1395w–3(a)(1)) is amended by adding at the end
 16 the following new subparagraph:

17 “(G) REQUIRING STATE LICENSURE OF
 18 BIDDING ENTITIES.—With respect to rounds of
 19 competitions beginning on or after the date of
 20 enactment of this subparagraph, the Secretary
 21 may only accept a bid from an entity for an
 22 area if the entity meets applicable State licen-
 23 sure requirements for such area for all items in
 24 such bid.”.

1 **SEC. 248. RECOGNITION OF ATTENDING PHYSICIAN ASSIST-**
 2 **ANTS AS ATTENDING PHYSICIANS TO SERVE**
 3 **HOSPICE PATIENTS.**

4 (a) RECOGNITION OF ATTENDING PHYSICIAN AS-
 5 SISTANTS AS ATTENDING PHYSICIANS TO SERVE HOS-
 6 PICE PATIENTS.—

7 (1) IN GENERAL.—Section 1861(dd)(3)(B) of
 8 the Social Security Act (42 U.S.C. 1395x(dd)(3)(B))
 9 is amended—

10 (A) by striking “or nurse” and inserting “,
 11 the nurse”; and

12 (B) by inserting “, or the physician assist-
 13 ant (as defined in such subsection)” after “sub-
 14 section (aa)(5))”.

15 (2) CLARIFICATION OF HOSPICE ROLE OF PHY-
 16 SICIAN ASSISTANTS.—Section 1814(a)(7)(A)(i)(I) of
 17 the Social Security Act (42 U.S.C.
 18 1395f(a)(7)(A)(i)(I)) is amended by inserting “or a
 19 physician assistant” after “a nurse practitioner”.

20 (b) EFFECTIVE DATE.—The amendments made by
 21 this section shall apply to items and services furnished on
 22 or after January 1, 2015.

23 **SEC. 249. REMOTE PATIENT MONITORING PILOT**
 24 **PROJECTS.**

25 (a) PILOT PROJECTS.—

1 (1) IN GENERAL.—Not later than 9 months
2 after the date of the enactment of this Act, the Sec-
3 retary shall conduct pilot projects under title XVIII
4 of the Social Security Act for the purpose of pro-
5 viding incentives to home health agencies to furnish
6 remote patient monitoring services that reduce ex-
7 penditures under such title.

8 (2) SITE REQUIREMENTS.—

9 (A) URBAN AND RURAL.—The Secretary
10 shall conduct the pilot projects under this sec-
11 tion in both urban and rural areas.

12 (B) SITE IN A SMALL STATE.—The Sec-
13 retary shall conduct at least 1 of the pilot
14 projects in a State with a population of less
15 than 1,000,000.

16 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
17 OF PROJECTS.—

18 (1) IN GENERAL.—The Secretary shall specify
19 the criteria for identifying those Medicare bene-
20 ficiaries who shall be considered within the scope of
21 the pilot projects under this section for purposes of
22 the application of subsection (c) and for the assess-
23 ment of the effectiveness of the home health agency
24 in achieving the objectives of this section.

1 (2) CRITERIA.—The criteria specified under
2 paragraph (1)—

3 (A) shall include conditions and clinical
4 circumstances, including congestive heart fail-
5 ure, diabetes, and chronic pulmonary obstruc-
6 tive disease, and other conditions determined
7 appropriate by the Secretary; and

8 (B) may provide for the inclusion in the
9 projects of Medicare beneficiaries who begin re-
10 ceiving home health services under title XVIII
11 of the Social Security Act after the date of the
12 implementation of the projects.

13 (c) INCENTIVES.—

14 (1) PERFORMANCE TARGETS.—The Secretary
15 shall establish for each home health agency partici-
16 pating in a pilot project under this section a per-
17 formance target using one of the following meth-
18 odologies, as determined appropriate by the Sec-
19 retary:

20 (A) ADJUSTED HISTORICAL PERFORMANCE
21 TARGET.—The Secretary shall establish for the
22 agency—

23 (i) a base expenditure amount equal
24 to the average total payments made under
25 parts A, B, and D of title XVIII of the So-

1 cial Security Act for Medicare beneficiaries
2 determined to be within the scope of the
3 pilot project in a base period determined
4 by the Secretary; and

5 (ii) an annual per capita expenditure
6 target for such beneficiaries, reflecting the
7 base expenditure amount adjusted for risk,
8 changes in costs, and growth rates.

9 (B) COMPARATIVE PERFORMANCE TAR-
10 GET.—The Secretary shall establish for the
11 agency a comparative performance target equal
12 to the average total payments made under such
13 parts A, B, and D during the pilot project for
14 comparable individuals in the same geographic
15 area that are not determined to be within the
16 scope of the pilot project.

17 (2) PAYMENT.—Subject to paragraph (3), the
18 Secretary shall pay to each home health agency par-
19 ticipating in a pilot project a payment for each year
20 under the pilot project equal to a 75 percent share
21 of the total Medicare cost savings realized for such
22 year relative to the performance target under para-
23 graph (1).

24 (3) LIMITATION ON EXPENDITURES.—The Sec-
25 retary shall limit payments under this section in

1 order to ensure that the aggregate expenditures
2 under title XVIII of the Social Security Act (includ-
3 ing payments under this subsection) do not exceed
4 the amount that the Secretary estimates would have
5 been expended if the pilot projects under this section
6 had not been implemented, including any reasonable
7 costs incurred by the Secretary in the administration
8 of the pilot projects.

9 (4) NO DUPLICATION IN PARTICIPATION IN
10 SHARED SAVINGS PROGRAMS.—A home health agen-
11 cy that participates in any of the following shall not
12 be eligible to participate in the pilot projects under
13 this section:

14 (A) A model tested or expanded under sec-
15 tion 1115A of the Social Security Act (42
16 U.S.C. 1315a) that involves shared savings
17 under title XVIII of such Act or any other pro-
18 gram or demonstration project that involves
19 such shared savings.

20 (B) The independence at home medical
21 practice demonstration program under section
22 1866E of such Act (42 U.S.C. 1395cc-5).

23 (d) WAIVER AUTHORITY.—The Secretary may waive
24 such provisions of titles XI and XVIII of the Social Secu-

1 rity Act as the Secretary determines to be appropriate for
2 the conduct of the pilot projects under this section.

3 (e) REPORT TO CONGRESS.—Not later than 3 years
4 after the date that the first pilot project under this section
5 is implemented, the Secretary shall submit to Congress a
6 report on the projects. Such report shall contain—

7 (1) a detailed description of the projects, in-
8 cluding any changes in clinical outcomes for Medi-
9 care beneficiaries under the projects, Medicare bene-
10 ficiary satisfaction under the projects, utilization of
11 items and services under parts A, B, and D of title
12 XVIII of the Social Security Act by Medicare bene-
13 ficiaries under the projects, and Medicare per-bene-
14 ficiary and Medicare aggregate spending under the
15 projects;

16 (2) a detailed description of issues related to
17 the expansion of the projects under subsection (f);

18 (3) recommendations for such legislation and
19 administrative actions as the Secretary considers ap-
20 propriate; and

21 (4) other items considered appropriate by the
22 Secretary.

23 (f) EXPANSION.—If the Secretary determines that
24 any of the pilot projects under this section enhance health
25 outcomes for Medicare beneficiaries and reduce expendi-

1 tures under title XVIII of the Social Security Act, the Sec-
2 retary shall initiate comparable projects in additional
3 areas.

4 (g) PAYMENTS HAVE NO EFFECT ON OTHER MEDI-
5 CARE PAYMENTS TO HOME HEALTH AGENCIES.—A pay-
6 ment under this section shall have no effect on the amount
7 of payments that a home health agency would otherwise
8 receive under title XVIII of the Social Security Act for
9 the provision of home health services.

10 (h) STUDY AND REPORT ON THE APPROPRIATE
11 VALUATION FOR REMOTE PATIENT MONITORING SERV-
12 ICES UNDER THE MEDICARE PHYSICIAN FEE SCHED-
13 ULE.—

14 (1) STUDY.—The Secretary shall conduct a
15 study on the appropriate valuation for remote pa-
16 tient monitoring services under the Medicare physi-
17 cian fee schedule under section 1848 of the Social
18 Security Act (42 U.S.C. 1395w-4) in order to accu-
19 rately reflect the resources involved in furnishing
20 such services.

21 (2) REPORT.—Not later than 6 months after
22 the date of the enactment of this Act, the Secretary
23 shall submit to Congress a report on the study con-
24 ducted under paragraph (1), together with such rec-

1 ommendations as the Secretary determines appro-
2 priate.

3 (i) DEFINITIONS.—In this section:

4 (1) HOME HEALTH AGENCY.—The term “home
5 health agency” has the meaning given that term in
6 section 1861(o) of the Social Security Act (42
7 U.S.C. 1395x(o)).

8 (2) REMOTE PATIENT MONITORING SERV-
9 ICES.—

10 (A) IN GENERAL.—The term “remote pa-
11 tient monitoring services” means services fur-
12 nished in the home using remote patient moni-
13 toring technology which—

14 (i) shall include patient monitoring or
15 patient assessment; and

16 (ii) may include in-home technology-
17 based professional consultations, patient
18 training services, clinical observation,
19 treatment, and any additional services that
20 utilize technologies specified by the Sec-
21 retary.

22 (B) LIMITATION.—The term “remote pa-
23 tient monitoring services” shall not include a
24 telecommunication that consists solely of a tele-
25 phone audio conversation, facsimile, or elec-

1 tronic text mail between a health care profes-
2 sional and a patient.

3 (3) REMOTE PATIENT MONITORING TECH-
4 NOLOGY.—The term “remote patient monitoring
5 technology” means a coordinated system that uses
6 one or more home-based or mobile monitoring de-
7 vices that automatically transmit vital sign data or
8 information on activities of daily living and may in-
9 clude responses to assessment questions collected on
10 the devices wirelessly or through a telecommuni-
11 cations connection to a server that complies with the
12 Federal regulations (concerning the privacy of indi-
13 vidually identifiable health information) promulgated
14 under section 264(c) of the Health Insurance Port-
15 ability and Accountability Act of 1996, as part of an
16 established plan of care for that patient that in-
17 cludes the review and interpretation of that data by
18 a health care professional.

19 (4) SECRETARY.—The term “Secretary” means
20 the Secretary of Health and Human Services.

21 **SEC. 250. COMMUNITY-BASED INSTITUTIONAL SPECIAL**
22 **NEEDS PLAN DEMONSTRATION PROGRAM.**

23 (a) IN GENERAL.—The Secretary of Health and
24 Human Services (referred to in this section as the “Sec-
25 retary”) shall establish a Community-Based Institutional

1 Special Needs Plan (CBI-SNP) demonstration program to
2 prevent and delay institutionalization under Medicaid
3 among targeted low-income Medicare beneficiaries.

4 (b) ESTABLISHMENT.—The Secretary shall enter into
5 agreements with not more than 5 specialized MA plans
6 for special needs individuals, as defined in section
7 1859(b)(6)(B)(i) of the Social Security Act (42 U.S.C.
8 1395w–28(b)(6)(B)(i)), to conduct the CBI-SNP dem-
9 onstration program. Under the CBI-SNP demonstration
10 program, a targeted low-income Medicare beneficiary shall
11 receive, as supplemental benefits under section 1852(a)(3)
12 of such Act (42 U.S.C. 1395w-22(a)(3)), long-term care
13 services or supports that—

14 (1) the Secretary determines appropriate for
15 the purposes of the CBI-SNP demonstration pro-
16 gram; and

17 (2) for which payment may be made under the
18 State plan under title XIX of such Act (42 U.S.C.
19 1396 et seq.) of the State in which the targeted low-
20 income Medicare beneficiary is located.

21 (c) ELIGIBLE PLANS.—To be eligible to participate
22 in the CBI-SNP demonstration program, a specialized MA
23 plan for special needs individuals must—

1 (1) serve special needs individuals (as defined
2 in section 1859(b)(6)(B)(i) of the Social Security
3 Act (42 U.S.C. 1395w-28(b)(6)(B)(i));

4 (2) have experience in offering special needs
5 plans for nursing home-eligible, non-institutionalized
6 Medicare beneficiaries who live in the community;

7 (3) be located in a State that the Secretary has
8 determined will participate in the CBI-SNP dem-
9 onstration program by agreeing to make available
10 data necessary for purposes of conducting the inde-
11 pendent evaluation required under subsection (f);
12 and

13 (4) meet such other criteria as the Secretary
14 may require.

15 (d) TARGETED LOW-INCOME MEDICARE BENE-
16 FICIARY DEFINED.—In this section, the term “targeted
17 low-income Medicare beneficiary” means a Medicare bene-
18 ficiary who—

19 (1) is enrolled in a specialized MA plan for spe-
20 cial needs individuals that has been selected to par-
21 ticipate in the CBI-SNP demonstration program;

22 (2) is a subsidy eligible individual (as defined in
23 section 1860D-14(a)(3)(A) of the Social Security
24 Act (42 U.S.C. 1395w-114(a)(3)(A)); and

1 (3) is unable to perform 2 or more activities of
2 daily living (as defined in section 7702B(e)(2)(B) of
3 the Internal Revenue Code of 1986).

4 (e) IMPLEMENTATION DEADLINE; DURATION.—The
5 CBI-SNP demonstration program shall be implemented
6 not later than January 1, 2016, and shall be conducted
7 for a period of 3 years.

8 (f) INDEPENDENT EVALUATION AND REPORTS.—

9 (1) INDEPENDENT EVALUATION.—Not later
10 than 2 years after the completion of the CBI-SNP
11 demonstration program, the Secretary shall provide
12 for the evaluation of the CBI-SNP demonstration
13 program by an independent third party. The evalua-
14 tion shall determine whether the CBI-SNP dem-
15 onstration program has improved patient care and
16 quality of life for the targeted low-income Medicare
17 beneficiaries participating in the CBI-SNP dem-
18 onstration program. Specifically, the evaluation shall
19 determine if the CBI-SNP demonstration program
20 has—

21 (A) reduced hospitalizations or re-hos-
22 pitalizations;

23 (B) reduced Medicaid nursing home facility
24 stays; and

1 (C) reduced spenddown of income and as-
2 sets for purposes of becoming eligible for Med-
3 icaid.

4 (2) REPORTS.—Not later than 3 years after the
5 completion of the CBI-SNP demonstration program,
6 the Secretary shall submit to Congress a report con-
7 taining the results of the evaluation conducted under
8 paragraph (1), together with such recommendations
9 for legislative or administrative action as the Sec-
10 retary determines appropriate.

11 (g) FUNDING.—

12 (1) FUNDING FOR IMPLEMENTATION.—For
13 purposes of carrying out the demonstration program
14 under this section (other than the evaluation and re-
15 port under subsection (f)), the Secretary shall pro-
16 vide for the transfer from the Federal Hospital In-
17 surance Trust Fund under section 1817 of the So-
18 cial Security Act (42 U.S.C. 1395i) and the Federal
19 Supplementary Medical Insurance Trust Fund under
20 section 1841 of such Act (42 U.S.C. 1395t), in such
21 proportion as the Secretary determines appropriate,
22 of \$3,000,000 to the Centers for Medicare & Med-
23 icaid Services Program Management Account.

24 (2) FUNDING FOR EVALUATION AND REPORT.—
25 For purposes of carrying out the evaluation and re-

1 port under subsection (f), the Secretary shall provide
2 for the transfer from the Federal Hospital Insurance
3 Trust Fund under such section 1817 and the Fed-
4 eral Supplementary Medical Insurance Trust Fund
5 under such section 1841, in such proportion as the
6 Secretary determines appropriate, of \$500,000.

7 (3) AVAILABILITY.—Amounts transferred under
8 paragraph (1) or (2) shall remain available until ex-
9 pended.

10 (h) BUDGET NEUTRALITY.—In conducting the CBI-
11 SNP demonstration program, the Secretary shall ensure
12 that the aggregate payments made by the Secretary do
13 not exceed the amount which the Secretary estimates
14 would have been expended under titles XVIII and XIX
15 of the Social Security Act (42 U.S.C. 1395 et seq., 1396
16 et seq.) if the CBI-SNP demonstration program had not
17 been implemented.

18 (i) PAPERWORK REDUCTION ACT.—Chapter 35 of
19 title 44, United States Code, shall not apply to the testing
20 and evaluation of the CBI-SNP demonstration program
21 under this section.

1 **SEC. 251. APPLYING CMMI WAIVER AUTHORITY TO PACE IN**
2 **ORDER TO FOSTER INNOVATIONS.**

3 (a) CMMI WAIVER AUTHORITY.—Subsection (d)(1)
4 of section 1115A of the Social Security Act (42 U.S.C.
5 1315a) is amended—

6 (1) by inserting “(other than subsections
7 (b)(1)(A) and (c)(5) of section 1894)” after
8 “XVIII”; and

9 (2) by striking “and 1903(m)(2)(A)(iii)” and
10 inserting “1903(m)(2)(A)(iii), and 1934 (other than
11 subsections (b)(1)(A) and (c)(5) of such section)”.

12 (b) SENSE OF THE SENATE.—It is the sense of the
13 Senate that the Secretary of Health and Human Services
14 should use the waiver authority provided under the
15 amendments made by this section to provide, in a budget
16 neutral manner, programs of all-inclusive care for the el-
17 derly (PACE programs) with increased operational flexi-
18 bility to support the ability of such programs to improve
19 and innovate and to reduce technical and administrative
20 barriers that have hindered enrollment in such programs.

21 **SEC. 252. IMPROVE AND MODERNIZE MEDICAID DATA SYS-**
22 **TEMS AND REPORTING.**

23 (a) IN GENERAL.—The Secretary of Health and
24 Human Services shall implement a strategic plan to in-
25 crease the usefulness of data about State Medicaid pro-
26 grams reported by States to the Centers for Medicare &

1 Medicaid Services. The strategic plan shall address
2 redundancies and gaps in Medicaid data systems and re-
3 porting through improvements to, and modernization of,
4 computer and data systems. Areas for improvement under
5 the plan shall include (but not be limited to) the following:

6 (1) The reporting of encounter data by man-
7 aged care plans.

8 (2) The timeliness and quality of reported data,
9 including enrollment data.

10 (3) The consistency of data reported from mul-
11 tiple sources.

12 (4) Information about State program policies.

13 (b) IMPLEMENTATION STATUS REPORT.—Not later
14 than 1 year after the date of enactment of this Act, the
15 Secretary of Health and Human Services shall submit a
16 report to Congress on the status of the implementation
17 of the strategic plan required under subsection (a).

18 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
19 authorized to be appropriated to the Secretary of Health
20 and Human Services for the period of fiscal years 2015
21 through 2109, such sums as may be necessary to carry
22 out this section.

1 **SEC. 253. FAIRNESS IN MEDICAID SUPPLEMENTAL NEEDS**
2 **TRUSTS.**

3 (a) IN GENERAL.—Section 1917(d)(4)(A) of the So-
4 cial Security Act (42 U.S.C. 1396p(d)(4)(A)) is amended
5 by inserting “the individual,” after “for the benefit of such
6 individual by”.

7 (b) EFFECTIVE DATE.—The amendment made by
8 subsection (a) shall apply to trusts established on or after
9 the date of the enactment of this Act.

10 **SEC. 254. HELPING ENSURE LIFE- AND LIMB-SAVING AC-**
11 **CESS TO PODIATRIC PHYSICIANS.**

12 (a) INCLUDING PODIATRISTS AS PHYSICIANS UNDER
13 THE MEDICAID PROGRAM.—

14 (1) IN GENERAL.—Section 1905(a)(5)(A) of the
15 Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is
16 amended by striking “section 1861(r)(1)” and in-
17 serting “paragraphs (1) and (3) of section 1861(r)”.

18 (2) EFFECTIVE DATE.—

19 (A) IN GENERAL.—Except as provided in
20 subparagraph (B), the amendment made by
21 paragraph (1) shall apply to services furnished
22 on or after the date of enactment of this Act.

23 (B) EXTENSION OF EFFECTIVE DATE FOR
24 STATE LAW AMENDMENT.—In the case of a
25 State plan under title XIX of the Social Secu-
26 rity Act (42 U.S.C. 1396 et seq.) which the

1 Secretary of Health and Human Services deter-
2 mines requires State legislation in order for the
3 plan to meet the additional requirement im-
4 posed by the amendment made by paragraph
5 (1), the State plan shall not be regarded as fail-
6 ing to comply with the requirements of such
7 title solely on the basis of its failure to meet
8 these additional requirements before the first
9 day of the first calendar quarter beginning after
10 the close of the first regular session of the
11 State legislature that begins after the date of
12 enactment of this Act. For purposes of the pre-
13 vious sentence, in the case of a State that has
14 a 2-year legislative session, each year of the ses-
15 sion is considered to be a separate regular ses-
16 sion of the State legislature.

17 (b) MODIFICATIONS TO REQUIREMENTS FOR DIA-
18 BETIC SHOES TO BE INCLUDED UNDER MEDICAL AND
19 OTHER HEALTH SERVICES UNDER MEDICARE.—

20 (1) IN GENERAL.—Section 1861(s)(12) of the
21 Social Security Act (42 U.S.C. 1395x(s)(12)) is
22 amended to read as follows:

23 “(12) subject to section 4072(e) of the Omni-
24 bus Budget Reconciliation Act of 1987, extra-depth
25 shoes with inserts or custom molded shoes (in this

1 paragraph referred to as ‘therapeutic shoes’) with
2 inserts for an individual with diabetes, if—

3 “(A) the physician who is managing the in-
4 dividual’s diabetic condition—

5 “(i) documents that the individual has
6 diabetes;

7 “(ii) certifies that the individual is
8 under a comprehensive plan of care related
9 to the individual’s diabetic condition; and

10 “(iii) documents agreement with the
11 prescribing podiatrist or other qualified
12 physician (as established by the Secretary)
13 that it is medically necessary for the indi-
14 vidual to have such extra-depth shoes with
15 inserts or custom molded shoes with in-
16 serts;

17 “(B) the therapeutic shoes are prescribed
18 by a podiatrist or other qualified physician (as
19 established by the Secretary) who—

20 “(i) examines the individual and de-
21 termines the medical necessity for the indi-
22 vidual to receive the therapeutic shoes; and

23 “(ii) communicates in writing the
24 medical necessity to the physician de-
25 scribed in subparagraph (A) for the indi-

1 vidual to have therapeutic shoes along with
2 findings that the individual has peripheral
3 neuropathy with evidence of callus forma-
4 tion, a history of pre-ulcerative calluses, a
5 history of previous ulceration, foot deform-
6 ity, previous amputation, or poor circula-
7 tion; and

8 “(C) the therapeutic shoes are fitted and
9 furnished by a podiatrist or other qualified sup-
10 plier (as established by the Secretary), such as
11 a pedorthist or orthotist, who is not the physi-
12 cian described in subparagraph (A) (unless the
13 Secretary finds that the physician is the only
14 such qualified individual in the area);”.

15 (2) EFFECTIVE DATE.—The amendment made
16 by paragraph (1) shall apply with respect to items
17 and services furnished on or after January 1, 2015.

18 **SEC. 255. DEMONSTRATION PROGRAM TO IMPROVE COM-**
19 **MUNITY MENTAL HEALTH SERVICES.**

20 (a) ESTABLISHMENT.—Not later than January 1,
21 2016, the Secretary of Health and Human Services (re-
22 ferred to in this section as the “Secretary”), in coordina-
23 tion with the Administrator of the Substance Abuse and
24 Mental Health Services Administration, shall award plan-
25 ning grants to not to exceed 10 States to enable such

1 States to carry out 5-year demonstration programs to im-
2 prove the provision of behavioral health services provided
3 by certified community behavioral health clinics in the
4 State.

5 (b) ELIGIBILITY.—

6 (1) APPLICATION.—To be eligible to receive a
7 grant under subsection (a), a State shall—

8 (A) submit to the Secretary an application
9 at such time, in such manner, and containing
10 such information as the Secretary may require;

11 (B) certify to the Secretary that behavioral
12 health providers that are provided assistance
13 under the demonstration program meet the cri-
14 teria for certified community behavioral health
15 clinics under subsection (c);

16 (C) conduct a financial assessment of the
17 demonstration program to be carried out under
18 the grant by providing a detailed estimate of el-
19 igible clinics and Medicaid expenditures over
20 the entire projected period of the demonstration
21 program; and

22 (D) comply with any other requirement de-
23 termined appropriate by the Secretary.

24 (2) WAIVER OF MEDICAID REQUIREMENT.—In
25 approving States to conduct demonstration programs

1 under this section, the Secretary shall waive section
2 1902(a)(1) of the Social Security Act (42 U.S.C.
3 1396a(a)(1)) (relating to statewideness) as may be
4 necessary to conduct the demonstration program in
5 accordance with the requirements of this section

6 (c) CRITERIA.—

7 (1) CRITERIA FOR CERTIFIED COMMUNITY BE-
8 HAVIORAL HEALTH CLINICS.—The criteria referred
9 to in subsection (b)(1)(B) are that the center per-
10 forms each of the following:

11 (A) Provide services in locations that en-
12 sure services will be available and accessible
13 promptly and in a manner which preserves
14 human dignity and assures continuity of care.

15 (B) Provide services in a mode of service
16 delivery appropriate for the target population.

17 (C) Provide individuals with a choice of
18 service options, including developmentally ap-
19 propriate evidence based interventions, where
20 there is more than one efficacious treatment.

21 (D) Employ a core clinical staff that is
22 trained to provide evidence-based practices and
23 is multidisciplinary and culturally and linguis-
24 tically competent, including the availability of
25 translation or similar services and arrange-

1 ments if the clinic is located in a geographic
2 area of limited English-speaking ability.

3 (E) Establish an emergency plan to sup-
4 port continuity of services for individuals during
5 an emergency or disaster.

6 (F) Demonstrate the capacity to comply
7 with behavioral health and related health care
8 quality measures promulgated by such entities
9 as the National Quality Forum, the National
10 Committee for Quality Assurance, or other na-
11 tionally recognized accrediting bodies.

12 (G) Provide services to any individual re-
13 siding or employed in the service area of the
14 clinic and ensure that no patient or consumer
15 will be denied mental health or other health
16 care services due to an individual's inability to
17 pay for such services.

18 (H) Ensure that any fees or payments re-
19 quired by the clinic for such services will be im-
20 posed for individuals eligible for medical assist-
21 ance under the State Medicaid plan under title
22 XIX of the Social Security Act in accordance
23 with the requirements of such State plan and
24 for any other individuals will be reduced or
25 waived to enable the clinic to comply with sub-

1 paragraph (G), including preparing a schedule
2 of fees or payments for the provision of services
3 that is consistent with locally prevailing rates or
4 charges designed to cover the reasonable costs
5 to the clinic of operation along with a cor-
6 responding schedule of discounts to be applied
7 to the payment of such fees or payments, such
8 discounts to be adjusted on the basis of the pa-
9 tient's ability to pay.

10 (I) Report required encounter data, clinical
11 outcomes data, and quality data.

12 (J) Provide, directly or through contract,
13 to the extent covered for adults in the State
14 Medicaid plan under title XIX of the Social Se-
15 curity Act and for children in accordance with
16 section 1905(r) of such Act regarding early and
17 periodic screening, diagnosis, and treatment,
18 each of the following services:

19 (i) Screening, assessment, and diag-
20 nosis, including risk assessment.

21 (ii) Person-centered treatment plan-
22 ning or similar processes, including risk as-
23 sessment and crisis planning.

24 (iii) Outpatient mental health and
25 substance use services, including screening,

1 assessment, diagnosis, psychotherapy, cog-
2 nitive behavioral therapy, applied behav-
3 ioral analysis, medication management,
4 and integrated treatment for trauma, men-
5 tal illness, and substance abuse which shall
6 be evidence-based (including cognitive be-
7 havioral therapy, long acting injectable
8 medications, and other such therapies
9 which are evidence-based).

10 (iv) Outpatient clinic primary care
11 screening and monitoring of key health in-
12 dicators and health risk (including screen-
13 ing for diabetes, hypertension, and cardio-
14 vascular disease and monitoring of weight,
15 height, body mass index (BMI), blood pres-
16 sure, blood glucose or HbA1C, and lipid
17 profile).

18 (v) Crisis mental health services, in-
19 cluding 24-hour mobile crisis teams, emer-
20 gency crisis intervention services, and cri-
21 sis stabilization.

22 (vi) Targeted case management (serv-
23 ices to assist individuals gaining access to
24 needed medical, social, educational, and
25 other services and applying for income se-

1 curity and other benefits to which they
2 may be entitled), and care coordination.

3 (vii) Psychiatric rehabilitation services
4 including skills training, assertive commu-
5 nity treatment, family psychoeducation,
6 disability self-management, supported em-
7 ployment, supported housing services,
8 therapeutic foster care services, and such
9 other evidence-based practices as the Sec-
10 retary may require.

11 (viii) Peer support and counselor serv-
12 ices and family supports.

13 (K) Maintain linkages, and where possible
14 enter into formal contracts, agreements, or
15 partnerships with at least one federally quali-
16 fied health center, unless there is no such cen-
17 ter serving the service area, in order to ensure
18 that the delivery of behavioral health care is in-
19 tegrated with primary and preventive care serv-
20 ices, so long as such linkages, contract, agree-
21 ment, or partnership meets requirements as
22 prescribed by the Secretary;

23 (L) Maintain additional linkages and
24 where possible enter into formal contracts with
25 the following:

1 (i) Inpatient psychiatric facilities and
2 substance use detoxification, post-detoxi-
3 fication step-down services, and residential
4 programs.

5 (ii) Adult and youth peer support and
6 counselor services.

7 (iii) Family support services for fami-
8 lies of children with serious mental or sub-
9 stance use disorders.

10 (iv) Other community or regional
11 services, supports, and providers, including
12 schools, child welfare agencies, juvenile and
13 criminal justice agencies and facilities, In-
14 dian Health Service youth regional treat-
15 ment centers, housing agencies and pro-
16 grams, employers, State licensed and na-
17 tionally accredited child placing agencies
18 for therapeutic foster care service, and
19 other social and human services.

20 (v) Onsite or offsite access to primary
21 care services.

22 (vi) Enabling services, including out-
23 reach, transportation, and translation.

24 (vii) Health and wellness services, in-
25 cluding services for tobacco cessation.

1 (viii) Department of Veterans Affairs
2 medical centers, independent outpatient
3 clinics, drop-in centers, and other facilities
4 of the Department as defined in section
5 1801 of title 38, United States Code.

6 (ix) Inpatient acute care hospitals and
7 hospital outpatient clinics.

8 (M) Where feasible, provide outreach and
9 engagement to encourage individuals who could
10 benefit from mental health care to freely par-
11 ticipate in receiving the administrative services
12 described in this subsection.

13 (N) Where feasible, provide intensive, com-
14 munity-based mental health care for members
15 of the armed forces and veterans, particularly
16 those members and veterans located in rural
17 areas, such care to be consistent with minimum
18 clinical mental health guidelines promulgated by
19 the Veterans Health Administration including
20 clinical guidelines contained in the Uniform
21 Mental Health Services Handbook of such Ad-
22 ministration.

23 (O) Where feasible, require certified com-
24 munity behavioral health clinics to provide valid
25 and reliable trauma screening and functional or

1 developmental assessment to determine need,
2 match services to needs, and to measure
3 progress over time.

4 (2) REGULATIONS.—Prior to the selection of
5 participating States, and not later than 18 months
6 after the date of the enactment of this Act, the Sec-
7 retary, in consultation with the Substance Abuse
8 and Mental Health Services Administration and the
9 State Mental Health and Substance Abuse Authori-
10 ties, shall issue final regulations for certifying non-
11 profit and local government behavioral health au-
12 thorities and Indian Health Service tribal facilities
13 as community behavioral health clinics.

14 (d) REQUIREMENTS.—In awarding grants under this
15 section, the Secretary shall—

16 (1) ensure the geographic diversity of grantee
17 States;

18 (2) ensure that certified community behavioral
19 health clinics in such States that are located in rural
20 areas, as defined by the Secretary, and other mental
21 health professional shortage areas are fairly and ap-
22 propriately considered with the objective of facili-
23 tating access to mental health services in such areas;

24 (3) take into account the ability of clinics in
25 such States to provide required services, and the

1 ability of such clinics to report required data as re-
2 quired under this section; and

3 (4) take into account the ability of such States
4 to provide such required services on a statewide
5 basis.

6 (e) EXEMPTION.—For purposes of this section, cer-
7 tified community behavioral health clinics that receive pay-
8 ments under section 1902(bb) of the Social Security Act
9 which are located in rural areas, as defined by the Sec-
10 retary, shall be exempt from the requirements contained
11 in subparagraphs (A) and (J)(v) of subsection (c)(1).

12 (f) TREATMENT OF CERTAIN SERVICES PROVIDED
13 BY COMMUNITY BEHAVIORAL HEALTH CLINICS AS MED-
14 ICAL ASSISTANCE.—

15 (1) IN GENERAL.—For purposes of the dem-
16 onstration program under this section, community
17 behavioral health clinic services (as defined in sub-
18 section (h)(1)) that are provided by certified commu-
19 nity behavioral health clinics receiving assistance
20 under this section shall be considered medical assist-
21 ance for purposes of payments to States under para-
22 graph (3)(C).

23 (2) GRANT CONDITION.—As a condition of re-
24 ceiving a grant under this section, a State shall
25 agree to provide for payment for community behav-

1 ioral health clinic services in accordance with the
2 prospective payment system established by the Sec-
3 retary under paragraph (3).

4 (3) PROSPECTIVE PAYMENT SYSTEM.—

5 (A) IN GENERAL.—Not later than 18
6 months after the date of enactment of this Act,
7 the Secretary shall establish a prospective pay-
8 ment system for community behavioral health
9 clinic services furnished by a community behav-
10 ioral health clinic receiving assistance under
11 this section in the same manner as payments
12 are required to be made under section 1902(bb)
13 of the Social Security Act (42 U.S.C.
14 1396a(bb)) for services described in section
15 1905(a)(2)(C) of such Act (42 U.S.C.
16 1396d(a)(2)(C)) furnished by a Federally-quali-
17 fied health center and services described in sec-
18 tion 1905(a)(2)(B) of such Act (42 U.S.C.
19 1396d(a)(2)(B)) furnished by a rural health
20 clinic.

21 (B) REQUIREMENTS.—The prospective
22 payment system established by the Secretary
23 under subparagraph (A) shall provide that—

24 (i) no payment shall be made for in-
25 patient care, residential treatment, room

1 and board expenses, or any other non-am-
2 bulatory services, as determined by the
3 Secretary; and

4 (ii) no payment shall be made to sat-
5 ellite facilities of community behavioral
6 health clinics if such facilities are estab-
7 lished after the date of enactment of this
8 Act.

9 (C) PAYMENTS TO STATES.—The Sec-
10 retary shall pay each State awarded a grant
11 under this section an amount each quarter
12 equal to the enhanced FMAP (as defined in
13 section 2105(b) of the Social Security Act (42
14 U.S.C. 1397dd(b)) but without regard to the
15 second and third sentences of that section) of
16 the State's expenditures in the quarter for med-
17 ical assistance for community behavioral health
18 clinic services provided by certified community
19 behavioral health clinics in the State that re-
20 ceive assistance under this section. Payments to
21 States made under this subparagraph shall be
22 considered to have been under, and are subject
23 to the requirements of, section 1903 of the So-
24 cial Security Act (42 U.S.C. 1396b).

25 (g) ANNUAL REPORT.—

1 (1) IN GENERAL.—Not later than 1 year after
2 the date on which the first grants are awarded
3 under this section, and annually thereafter, the Sec-
4 retary shall submit to Congress an annual report on
5 the use of funds provided under the demonstration
6 program. Each such report shall include—

7 (A) an assessment of access to community-
8 based mental health services under the Med-
9 icaid program in the States awarded such
10 grants;

11 (B) an assessment of the quality and scope
12 of services provided by certified community be-
13 havioral health clinics under the grants as com-
14 pared against community-based mental health
15 services provided in States that are not receiv-
16 ing such grants; and

17 (C) an assessment of the impact of the
18 demonstration programs on the costs of a full
19 range of mental health services (including inpa-
20 tient, emergency and ambulatory services).

21 (2) RECOMMENDATIONS.—Not later than De-
22 cember 31, 2019, the Secretary shall submit to Con-
23 gress recommendations concerning whether the dem-
24 onstration programs under this section should be
25 continued and expanded on a national basis.

1 (h) DEFINITIONS.—In this section:

2 (1) COMMUNITY BEHAVIORAL HEALTH CLINIC
3 SERVICES.—The term “community behavioral health
4 clinic services” means ambulatory behavioral health
5 services of the type described in subparagraphs (J),
6 (M), (N), and (O) of subsection (c)(1) that are pro-
7 vided by certified community behavioral health clin-
8 ics receiving assistance under this section.

9 (2) STATE.—The term “State” has the mean-
10 ing given such term for purposes of title XIX of the
11 Social Security Act (42 U.S.C. 1396 et seq.).

12 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
13 authorized to be appropriated to carry out this section,
14 \$50,000,000 for fiscal year 2016, to remain available until
15 expended.

16 **SEC. 256. ANNUAL MEDICAID DSH REPORT.**

17 Section 1923 of the Social Security Act (42 U.S.C.
18 1396r-4) is amended by adding at the end the following:

19 “(k) ANNUAL REPORT TO CONGRESS.—

20 “(1) IN GENERAL.—Beginning January 1,
21 2015, and annually thereafter, the Secretary shall
22 submit a report to Congress on the program estab-
23 lished under this section for making payment adjust-
24 ments to disproportionate share hospitals for the
25 purpose of providing Congress with information rel-

1 evant to determining an appropriate level of overall
2 funding for such payment adjustments during and
3 after the period in which aggregate reductions in the
4 DSH allotments to States are required under para-
5 graphs (7) and (8) of subsection (f).

6 “(2) REQUIRED REPORT INFORMATION.—Ex-
7 cept as otherwise provided, each report submitted
8 under this subsection shall include the following:

9 “(A) Information and data relating to
10 changes in the number of uninsured individuals
11 for the most recent year for which such data
12 are available as compared to 2013 and as com-
13 pared to the Congressional Budget Office esti-
14 mates of uninsured individuals made at the
15 time of the enactment of the Patient Protection
16 and Affordable Care Act (Public Law 111–148)
17 and the Health Care and Education Reconcili-
18 ation Act of 2010 (Public Law 111–152).

19 “(B) Information and data relating to the
20 extent to which hospitals continue to incur un-
21 compensated care costs from providing unreim-
22 bursed or under-reimbursed services to individ-
23 uals who either are eligible for medical assist-
24 ance under the State plan under this title or
25 under a waiver of such plan or who have no

1 health insurance (or other source of third party
2 coverage) for such services.

3 “(C) Information and data relating to the
4 extent to which hospitals continue to provide
5 charity care and unreimbursed or under-reim-
6 bursed services, or otherwise incur bad debt,
7 under the program established under this title,
8 the State Children’s Health Insurance Program
9 established under title XXI, and State or local
10 indigent care programs, as reported on cost re-
11 ports submitted under title XVIII or such other
12 data as the Secretary determines appropriate.

13 “(D) In the first report submitted under
14 this section, a methodology for estimating the
15 amount of unpaid patient deductibles, copay-
16 ments and coinsurance incurred by hospitals for
17 patients enrolled in qualified health plans
18 through an American Health Benefits Ex-
19 change, using existing data and minimizing the
20 administrative burden on hospitals to the extent
21 possible, and in subsequent reports, data re-
22 garding such uncompensated care costs col-
23 lected pursuant to such methodology.

24 “(E) For each State, information and data
25 relating to the difference between the DSH al-

1 lotment for the State for the fiscal year that
2 began on October 1 of the year preceding the
3 year in which the report is submitted and the
4 aggregate amount of uncompensated care costs
5 for all disproportionate share hospitals in the
6 State.

7 “(F) Information and data relating to the
8 extent to which there are certain vital hospital
9 systems that are disproportionately experiencing
10 high levels of uncompensated care and that
11 have multiple other missions, such as a commit-
12 ment to graduate medical education, the provi-
13 sion of tertiary and trauma care services, pro-
14 viding public health and essential community
15 services, and providing comprehensive, coordi-
16 nated care.

17 “(G) Such other information and data rel-
18 evant to the determination of the level of fund-
19 ing for, and amount of, State DSH allotments
20 as the Secretary determines appropriate

21 “(3) AUTHORIZATION OF APPROPRIATIONS.—
22 There is authorized to be appropriated to the Sec-
23 retary for the period of fiscal years 2015 through
24 2109, such sums as may be necessary to carry out
25 this subsection.”.

1 **SEC. 257. IMPLEMENTATION.**

2 To the extent the Secretary of Health and Human
3 Services issues a regulation to carry out the provisions of
4 this Act, the Secretary shall, unless otherwise specified in
5 this Act—

6 (1) issue a notice of proposed rulemaking that
7 includes the proposed regulation;

8 (2) provide a period of not less than 60 cal-
9 endar days for comments on the proposed regula-
10 tion;

11 (3) not more than 24 months following the date
12 of publication of the proposed rule, publish the final
13 regulation or take alternative action (such as with-
14 drawing the rule or proposing a revised rule with a
15 new comment period) on the proposed regulation;
16 and

17 (4) not less than 30 days before the effective
18 date of the final regulation, publish the final regula-
19 tion or take alternative action (such as withdrawing
20 the rule or proposing a revised rule with a new com-
21 ment period) on the proposed regulation.

Calendar No. 280

113TH CONGRESS
1ST Session

S. 1871

A BILL

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate formula and to improve beneficiary access under the Medicare program, and for other purposes.

DECEMBER 19, 2013

Read twice and placed on the calendar