

Calendar No. 330113TH CONGRESS
2^D SESSION**S. 2122**

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

IN THE SENATE OF THE UNITED STATES

MARCH 12, 2014

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

MARCH 13, 2014

Read the second time and placed on the calendar

A BILL

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

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

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

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

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE PAYMENT FOR PHYSICIANS’ SERVICES

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

TITLE II—EXTENSIONS

Subtitle A—Medicare Extensions

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

Subtitle B—Medicaid and Other Extensions

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

Subtitle C—Human Services Extensions

- Sec. 221. Abstinence education grants.

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

TITLE III—MEDICARE AND MEDICAID PROGRAM INTEGRITY

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

TITLE IV—OTHER PROVISIONS

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

TITLE V—RESTORING INDIVIDUAL LIBERTY

- Sec. 501. Restoring individual liberty.

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

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

6 (a) STABILIZING FEE UPDATES.—

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

10 (A) in subsection (d)—

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

14 (ii) in paragraph (4)—

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

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

21 (B) in subsection (f)—

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

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

5 (2) UPDATE OF RATES FOR APRIL THROUGH
6 DECEMBER OF 2014, 2015, AND SUBSEQUENT
7 YEARS.—Subsection (d) of section 1848 of the Social
8 Security Act (42 U.S.C. 1395w-4) is amended by
9 striking paragraph (15) and inserting the following
10 new paragraphs:

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

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

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

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

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

3 (3) MEDPAC REPORTS.—

4 (A) INITIAL REPORT.—Not later than July
5 1, 2016, the Medicare Payment Advisory Com-
6 mission shall submit to Congress a report on
7 the relationship between—

8 (i) physician and other health profes-
9 sional utilization and expenditures (and the
10 rate of increase of such utilization and ex-
11 penditures) of items and services for which
12 payment is made under section 1848 of the
13 Social Security Act (42 U.S.C. 1395w-4);
14 and

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

19 Such report shall include a methodology to de-
20 scribe such relationship and the impact of
21 changes in such physician and other health pro-
22 fessional practice and service ordering patterns
23 on total utilization and expenditures under
24 parts A, B, and D of such title.

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

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

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

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

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

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

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

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

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

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

18 (ii) in clause (ii)—

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

23 (II) in subclause (III), by strik-
24 ing “and each subsequent year”; and
25 (iii) by striking clause (iii).

1 (B) CONTINUATION OF MEANINGFUL USE
2 DETERMINATIONS FOR MIPS.—Section
3 1848(o)(2) of the Social Security Act (42
4 U.S.C. 1395w-4(o)(2)) is amended—

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

7 (I) by striking “For purposes of
8 paragraph (1), an” and inserting
9 “An”; and

10 (II) by inserting “, or pursuant
11 to subparagraph (D) for purposes of
12 subsection (q), for a performance pe-
13 riod under such subsection for a year”
14 after “under such subsection for a
15 year”; and

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

18 “(D) CONTINUED APPLICATION FOR PUR-
19 POSES OF MIPS.—With respect to 2018 and
20 each subsequent payment year, the Secretary
21 shall, for purposes of subsection (q) and in ac-
22 cordance with paragraph (1)(F) of such sub-
23 section, determine whether an eligible profes-
24 sional who is a MIPS eligible professional (as
25 defined in subsection (q)(1)(C)) for such year is

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

4 (2) QUALITY REPORTING.—

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

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

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

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

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

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

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

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

5 (ii) in subsection (m)—

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

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

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

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

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

21 (3) VALUE-BASED PAYMENTS.—

22 (A) SUNSETTING SEPARATE VALUE-BASED
23 PAYMENTS.—Clause (iii) of section
24 1848(p)(4)(B) of the Social Security Act (42

1 U.S.C. 1395w-4(p)(4)(B)) is amended to read
2 as follows:

3 “(iii) APPLICATION.—The Secretary
4 shall apply the payment modifier estab-
5 lished under this subsection for items and
6 services furnished on or after January 1,
7 2015, but before January 1, 2018, with re-
8 spect to specific physicians and groups of
9 physicians the Secretary determines appro-
10 priate. Such payment modifier shall not be
11 applied for items and services furnished on
12 or after January 1, 2018.”.

13 (B) CONTINUATION OF VALUE-BASED PAY-
14 MENT MODIFIER MEASURES FOR MIPS.—Section
15 1848(p) of the Social Security Act (42 U.S.C.
16 1395w-4(p)) is amended—

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

19 “(C) CONTINUED APPLICATION FOR PUR-
20 POSES OF MIPS.—The Secretary shall, in ac-
21 cordance with subsection (q)(1)(F), carry out
22 subparagraph (B) for purposes of subsection
23 (q).”; and

24 (ii) in paragraph (3), by adding at the
25 end the following: “With respect to 2018

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

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

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

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

10 “(1) ESTABLISHMENT.—

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

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

23 “(ii) using such methodology, provide
 24 for a composite performance score in ac-
 25 cordance with paragraph (5) for each such

1 professional for each performance period;
2 and

3 “(iii) use such composite performance
4 score of the MIPS eligible professional for
5 a performance period for a year to deter-
6 mine and apply a MIPS adjustment factor
7 (and, as applicable, an additional MIPS
8 adjustment factor) under paragraph (6) to
9 the professional for the year.

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

13 “(C) MIPS ELIGIBLE PROFESSIONAL DE-
14 FINED.—

15 “(i) IN GENERAL.—For purposes of
16 this subsection, subject to clauses (ii) and
17 (iv), the term ‘MIPS eligible professional’
18 means—

19 “(I) for the first and second
20 years for which the MIPS applies to
21 payments (and for the performance
22 period for such first and second year),
23 a physician (as defined in section
24 1861(r)), a physician assistant, nurse
25 practitioner, and clinical nurse spe-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 “(i) IN GENERAL.—Under the MIPS:

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

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

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

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

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

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

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

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

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

8 “(G) ACCOUNTING FOR RISK FACTORS.—

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

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

1 recommendations made in reports under
2 section 101(f)(1) of the Responsible Medi-
3 care SGR Repeal and Beneficiary Access
4 Improvement Act of 2014 and other infor-
5 mation as appropriate, the Secretary shall
6 account for identified factors with an effect
7 on quality and resource use outcome meas-
8 ures when determining payment adjust-
9 ments, composite performance scores,
10 scores for performance categories, or
11 scores for measures or activities under the
12 MIPS.

13 “(2) MEASURES AND ACTIVITIES UNDER PER-
14 FORMANCE CATEGORIES.—

15 “(A) PERFORMANCE CATEGORIES.—Under
16 the MIPS, the Secretary shall use the following
17 performance categories (each of which is re-
18 ferred to in this subsection as a performance
19 category) in determining the composite per-
20 formance score under paragraph (5):

21 “(i) Quality.

22 “(ii) Resource use.

23 “(iii) Clinical practice improvement
24 activities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 “(C) ADDITIONAL PROVISIONS.—

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

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

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

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

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

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

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

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

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

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

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

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

1 with entities to assist the Secretary
2 in—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 such list. For purposes of the previous
2 sentence, measures may be submitted
3 regardless of whether such measures
4 were previously published in a pro-
5 posed rule or endorsed by an entity
6 with a contract under section 1890(a).

7 “(II) ELIGIBLE PROFESSIONAL
8 ORGANIZATION DEFINED.—In this
9 subparagraph, the term ‘eligible pro-
10 fessional organization’ means a pro-
11 fessional organization as defined by
12 nationally recognized multispecialty
13 boards of certification or equivalent
14 certification boards.

15 “(iii) REQUIREMENTS.—In selecting
16 quality measures for inclusion in the an-
17 nual final list under clause (i), the Sec-
18 retary shall—

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

23 “(II) ensure that such selection
24 is consistent with the process for se-

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

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

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

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

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

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

1 Any measure selected for inclusion in such
2 list that is not endorsed by a consensus-
3 based entity shall have a focus that is evi-
4 dence-based.

5 “(vi) EXCEPTION FOR QUALIFIED
6 CLINICAL DATA REGISTRY MEASURES.—
7 Measures used by a qualified clinical data
8 registry under subsection (m)(3)(E) shall
9 not be subject to the requirements under
10 clauses (i), (iv), and (v). The Secretary
11 shall publish the list of measures used by
12 such qualified clinical data registries on
13 the Internet website of the Centers for
14 Medicare & Medicaid Services.

15 “(vii) EXCEPTION FOR EXISTING
16 QUALITY MEASURES.—Any quality meas-
17 ure specified by the Secretary under sub-
18 section (k) or (m), including under sub-
19 section (m)(3)(E), and any measure of
20 quality of care established under sub-
21 section (p)(2) for the reporting period
22 under the respective subsection beginning
23 before the first performance period under
24 the MIPS—

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

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

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

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

22 “(3) PERFORMANCE STANDARDS.—

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

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

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

9 “(i) Historical performance standards.

10 “(ii) Improvement.

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

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

22 “(5) COMPOSITE PERFORMANCE SCORE.—

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

1 graph (1)(G), the Secretary shall develop a
2 methodology for assessing the total performance
3 of each MIPS eligible professional according to
4 performance standards under paragraph (3)
5 with respect to applicable measures and activi-
6 ties specified in paragraph (2)(B) with respect
7 to each performance category applicable to such
8 professional for a performance period (as estab-
9 lished under paragraph (4)) for a year. Using
10 such methodology, the Secretary shall provide
11 for a composite assessment (using a scoring
12 scale of 0 to 100) for each such professional for
13 the performance period for such year. In this
14 subsection such a composite assessment for
15 such a professional with respect to a perform-
16 ance period shall be referred to as the ‘com-
17 posite performance score’ for such professional
18 for such performance period.

19 “(B) INCENTIVE TO REPORT; ENCOUR-
20 AGING USE OF CERTIFIED EHR TECHNOLOGY
21 FOR REPORTING QUALITY MEASURES.—

22 “(i) INCENTIVE TO REPORT.—Under
23 the methodology established under sub-
24 paragraph (A), the Secretary shall provide
25 that in the case of a MIPS eligible profes-

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

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

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

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

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

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

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

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

1 “(iii) SUBCATEGORIES.—A MIPS eli-
2 gible professional shall not be required to
3 perform activities in each subcategory
4 under paragraph (2)(B)(iii) or participate
5 in an alternative payment model in order
6 to achieve the highest potential score for
7 the performance category described in
8 paragraph (2)(A)(iii).

9 “(D) ACHIEVEMENT AND IMPROVE-
10 MENT.—

11 “(i) TAKING INTO ACCOUNT IMPROVE-
12 MENT.—Beginning with the second year to
13 which the MIPS applies, in addition to the
14 achievement of a MIPS eligible profes-
15 sional, if data sufficient to measure im-
16 provement is available, the methodology
17 developed under subparagraph (A)—

18 “(I) in the case of the perform-
19 ance score for the performance cat-
20 egory described in clauses (i) and (ii)
21 of paragraph (2)(A), shall take into
22 account the improvement of the pro-
23 fessional; and

24 “(II) in the case of performance
25 scores for other performance cat-

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

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

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

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

22 “(I) QUALITY.—

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

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

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

22 “(II) RESOURCE USE.—

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

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

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

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

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

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

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

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

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

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

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

1 ology described in subsection (r)(5), as appro-
2 priate.

3 “(H) INCLUSION OF QUALITY MEASURE
4 DATA FROM OTHER PAYERS.—In applying sub-
5 sections (k), (m), and (p) with respect to meas-
6 ures described in paragraph (2)(B)(i), analysis
7 of the performance category described in para-
8 graph (2)(A)(i) may include data submitted by
9 MIPS eligible professionals with respect to
10 items and services furnished to individuals who
11 are not individuals entitled to benefits under
12 part A or enrolled under part B.

13 “(I) USE OF VOLUNTARY VIRTUAL GROUPS
14 FOR CERTAIN ASSESSMENT PURPOSES.—

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

21 “(I) the assessment of perform-
22 ance provided under such methodology
23 with respect to the performance cat-
24 egories described in clauses (i) and
25 (ii) of paragraph (2)(A) that is to be

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

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

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

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

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

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

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

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

10 “(6) MIPS PAYMENTS.—

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

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

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

1 payments under this paragraph reflecting
2 that—

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

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

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

1 graph (F), receive a zero or positive ad-
2 justment factor on a linear sliding scale
3 such that an adjustment factor of 0 per-
4 cent is assigned for a score at the perform-
5 ance threshold and an adjustment factor of
6 the applicable percent specified in subpara-
7 graph (B) is assigned for a score of 100;
8 and

9 “(iv) in a manner such that—

10 “(I) subject to subclause (II),
11 MIPS eligible professionals with com-
12 posite performance scores described in
13 clause (ii)(II) for such year receive a
14 negative payment adjustment factor
15 on a linear sliding scale such that an
16 adjustment factor of 0 percent is as-
17 signed for a score at the performance
18 threshold and an adjustment factor of
19 the negative of the applicable percent
20 specified in subparagraph (B) is as-
21 signed for a score of 0; and

22 “(II) MIPS eligible professionals
23 with composite performance scores
24 that are equal to or greater than 0,
25 but not greater than $\frac{1}{4}$ of the per-

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

7 “(B) APPLICABLE PERCENT DEFINED.—

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

10 “(i) for 2018, 4 percent;

11 “(ii) for 2019, 5 percent;

12 “(iii) for 2020, 7 percent; and

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

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

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

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

10 “(ii) ADDITIONAL FUNDING POOL.—

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

18 “(D) ESTABLISHMENT OF PERFORMANCE

19 THRESHOLDS.—

20 “(i) PERFORMANCE THRESHOLD.—

21 For each year of the MIPS, the Secretary
22 shall compute a performance threshold
23 with respect to which the composite per-
24 formance score of MIPS eligible profes-
25 sionals shall be compared for purposes of

1 determining adjustment factors under sub-
2 paragraph (A) that are positive, negative,
3 and zero. Such performance threshold for
4 a year shall be the mean or median (as se-
5 lected by the Secretary) of the composite
6 performance scores for all MIPS eligible
7 professionals with respect to a prior period
8 specified by the Secretary. The Secretary
9 may reassess the selection under the pre-
10 vious sentence every 3 years.

11 “(ii) ADDITIONAL PERFORMANCE
12 THRESHOLD FOR EXCEPTIONAL PERFORM-
13 ANCE.—In addition to the performance
14 threshold under clause (i), for each year of
15 the MIPS, the Secretary shall compute an
16 additional performance threshold for pur-
17 poses of determining the additional MIPS
18 adjustment factors under subparagraph
19 (C)(i). For each such year, the Secretary
20 shall apply either of the following methods
21 for computing such additional performance
22 threshold for such a year:

23 “(I) The threshold shall be the
24 score that is equal to the 25th per-
25 centile of the range of possible com-

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

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

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

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

1 “(II) take into account—

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

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

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

18 “(i) 1, plus

19 “(ii) the sum of—

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

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

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

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

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

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

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

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

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

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

5 “(II) AGGREGATE INCREASES.—

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

18 “(III) AGGREGATE DE-

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

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

4 “(iii) EXCEPTIONS.—

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

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

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

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

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

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

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

5 “(9) PUBLIC REPORTING.—

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

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

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

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

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

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

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

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

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

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

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

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

1 professionals (with priority given to such practices
2 located in rural areas, health professional short-
3 age areas (as designated under in section
4 332(a)(1)(A) of such Act), and medically under-
5 served areas, and practices with low composite
6 scores) with respect to—

7 “(i) the performance categories de-
8 scribed in clauses (i) through (iv) of para-
9 graph (2)(A); or

10 “(ii) how to transition to the imple-
11 mentation of and participation in an alter-
12 native payment model as described in sec-
13 tion 1833(z)(3)(C).

14 “(B) FUNDING FOR IMPLEMENTATION.—

15 “(i) IN GENERAL.—For purposes of
16 implementing subparagraph (A), the Sec-
17 retary shall provide for the transfer from
18 the Federal Supplementary Medical Insur-
19 ance Trust Fund established under section
20 1841 to the Centers for Medicare & Med-
21 icaid Services Program Management Ac-
22 count of \$40,000,000 for each of fiscal
23 years 2015 through 2019. Amounts trans-
24 ferred under this subparagraph for a fiscal
25 year shall be available until expended.

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

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

11 “(A) PERFORMANCE FEEDBACK.—

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

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

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

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

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

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

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

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

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

16 “(B) ADDITIONAL INFORMATION.—

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

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

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

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

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

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

13 “(13) REVIEW.—

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

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

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

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

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

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

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

7 (2) GAO REPORTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

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

13 “(c) PHYSICIAN FOCUSED PAYMENT MODELS.—

14 “(1) TECHNICAL ADVISORY COMMITTEE.—

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

20 “(B) MEMBERSHIP.—

21 “(i) NUMBER AND APPOINTMENT.—

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

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

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

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

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

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

3 “(C) TERM; VACANCIES.—

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

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

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

24 “(E) COMPENSATION OF MEMBERS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 “(1) PAYMENT INCENTIVE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (4) ENCOURAGING DEVELOPMENT AND TEST-
9 ING OF CERTAIN MODELS.—Section 1115A(b)(2) of
10 the Social Security Act (42 U.S.C. 1315a(b)(2)) is
11 amended—

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

14 “(xxi) Focusing primarily on physi-
15 cians’ services (as defined in section
16 1848(j)(3)) furnished by physicians who
17 are not primary care practitioners.

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

20 “(xxiii) Focusing on risk-based models
21 for small physician practices which may in-
22 volve two-sided risk and prospective patient
23 assignment, and which examine risk-ad-
24 justed decreases in mortality rates, hos-

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

3 “(xxiv) Focusing primarily on title
4 XIX, working in conjunction with the Cen-
5 ter for Medicaid and CHIP Services.”; and
6 (B) in subparagraph (C)(viii), by striking
7 “other public sector or private sector payers”
8 and inserting “other public sector payers, pri-
9 vate sector payers, or Statewide payment mod-
10 els”.

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

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

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

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

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

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

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

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

1 under any potential expansion of such
2 models.

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

15 (f) IMPROVING PAYMENT ACCURACY.—

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

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

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

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

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

21 (B) STUDY USING OTHER DATA.—

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

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

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

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

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

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

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

18 (ii) account for such factors in deter-
19 mining payment adjustments based on
20 quality and resource use outcome measures
21 under the eligible professional Merit-based
22 Incentive Payment System under section
23 1848(q) of the Social Security Act (42
24 U.S.C. 1395w-4(q)) and, as the Secretary

1 determines appropriate, other similar pro-
2 visions of title XVIII of such Act.

3 (E) FUNDING.—There are hereby appro-
4 priated from the Federal Supplementary Med-
5 ical Insurance Trust Fund under section 1841
6 of the Social Security Act to the Secretary to
7 carry out this paragraph \$6,000,000, to remain
8 available until expended.

9 (2) CMS ACTIVITIES.—

10 (A) HIERARCHICAL CONDITION CATEGORY
11 (HCC) IMPROVEMENT.—Taking into account the
12 relevant studies conducted and recommenda-
13 tions made in reports under paragraph (1), the
14 Secretary, on an ongoing basis, shall, as the
15 Secretary determines appropriate, estimate how
16 an individual’s health status and other risk fac-
17 tors affect quality and resource use outcome
18 measures and, as feasible, shall incorporate in-
19 formation from quality and resource use out-
20 come measurement (including care episode and
21 patient condition groups) into provisions of title
22 XVIII of the Social Security Act that are simi-
23 lar to the eligible professional Merit-based In-
24 centive Payment System under section 1848(q)
25 of such Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 “(i) care episode groups; and

19 “(ii) patient condition groups.

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

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

1 ceived under subparagraph (C), the Sec-
2 retary shall—

3 “(I) establish care episode groups
4 and patient condition groups, which
5 account for a target of an estimated
6 $\frac{2}{3}$ of expenditures under parts A and
7 B; and

8 “(II) assign codes to such
9 groups.

10 “(ii) CARE EPISODE GROUPS.—In es-
11 tablishing the care episode groups under
12 clause (i), the Secretary shall take into ac-
13 count—

14 “(I) the patient’s clinical prob-
15 lems at the time items and services
16 are furnished during an episode of
17 care, such as the clinical conditions or
18 diagnoses, whether or not inpatient
19 hospitalization is anticipated or oc-
20 curs, and the principal procedures or
21 services planned or furnished; and

22 “(II) other factors determined
23 appropriate by the Secretary.

24 “(iii) PATIENT CONDITION GROUPS.—
25 In establishing the patient condition

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

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

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

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

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

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

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

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

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

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

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

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

14 “(i) considers themselves to have the
15 primary responsibility for the general and
16 ongoing care for the patient over extended
17 periods of time;

18 “(ii) considers themselves to be the lead
19 physician or practitioner and who furnishes
20 items and services and coordinates care
21 furnished by other physicians or practi-
22 tioners for the patient during an acute epi-
23 sode;

24 “(iii) furnishes items and services to
25 the patient on a continuing basis during an

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 “(C) MEASUREMENT OF RESOURCE USE.—
10 In measuring such resource use, the Sec-
11 retary—

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

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

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

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

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

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

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

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

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

12 “(9) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

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

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

1 tems could be incorporated under title
2 XVIII;

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

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

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

13 “(i) Clinical care.

14 “(ii) Safety.

15 “(iii) Care coordination.

16 “(iv) Patient and caregiver experience.

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

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

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

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

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

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

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

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

17 “(ii) Patient experience measures.

18 “(iii) Care coordination measures.

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

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

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

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

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

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

23 “(B) PRIORITIZATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 “(A) Subsection (q)(2)(B)(i).

23 “(B) Section 1833(z)(2)(C).

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

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

8 **SEC. 103. ENCOURAGING CARE MANAGEMENT FOR INDI-**
 9 **VIDUALS WITH CHRONIC CARE NEEDS.**

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

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

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

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

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

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

4 “(B) APPLICABLE PROVIDER DEFINED.—

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

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

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

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

1 “(D) POLICIES RELATING TO PAYMENT.—

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

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

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

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

20 (b) EDUCATION AND OUTREACH.—

21 (1) CAMPAIGN.—

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

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

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

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

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

19 (2) REPORT.—

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

1 and by racial and ethnic minority populations.

2 Such report shall—

3 (i) identify barriers to receiving chron-
4 ic care management services; and

5 (ii) make recommendations for in-
6 creasing the appropriate use of chronic
7 care management services.

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

10 (a) **AUTHORITY TO COLLECT AND USE INFORMA-**
11 **TION ON PHYSICIANS' SERVICES IN THE DETERMINATION**
12 **OF RELATIVE VALUES.—**

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

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

20 “(i) **COLLECTION OF INFORMATION.—**
21 Notwithstanding any other provision of
22 law, the Secretary may collect or obtain in-
23 formation on the resources directly or indi-
24 rectly related to furnishing services for
25 which payment is made under the fee

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

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

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

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

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

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

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

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

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

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

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

17 “(III) Electronic health records.

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

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

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

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

9 “(II) THRESHOLDS FOR USE.—

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

17 “(III) DISCLOSURE OF INFORMA-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the same service between different
2 sites of service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 “(I) the target for the year; and

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

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

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

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

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

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

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

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

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

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

19 (B) in subparagraph (K)(iii)(VI)—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(ii) Payment locality 3.

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

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

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

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

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

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

17 “(1) PROGRAM ESTABLISHED.—

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

1 professionals (as defined in subparagraphs (E)
2 and (F), respectively).

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

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

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

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

24 “(iii) one or more of such mechanisms
25 is available free of charge.

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

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

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

20 “(2) ESTABLISHMENT OF APPLICABLE APPRO-
21 PRIATE USE CRITERIA.—

22 “(A) IN GENERAL.—Not later than No-
23 vember 15, 2015, the Secretary shall through
24 rulemaking, and in consultation with physi-
25 cians, practitioners, and other stakeholders,

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

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

10 “(i) have stakeholder consensus;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 consulted by the ordering professional for
2 the service.

3 “(ii) Information regarding—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (3) The location of the eligible professional.

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

20 (e) IMPLEMENTATION.—

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

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

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

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

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

13 (g) DEFINITIONS.—In this section:

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

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

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

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

25 (1) ADDITIONAL ANALYSES.—

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

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

24 (i) EMPLOYERS.—Any analyses pro-
25 vided or sold under subparagraph (A) to

1 an employer described in paragraph
2 (9)(A)(iii) may only be used by such em-
3 ployer for purposes of providing health in-
4 surance to employees and retirees of the
5 employer.

6 (ii) HEALTH INSURANCE ISSUERS.—A
7 qualified entity may not provide or sell an
8 analysis to a health insurance issuer de-
9 scribed in paragraph (9)(A)(iv) unless the
10 issuer is providing the qualified entity with
11 data under section 1874(e)(4)(B)(iii) of
12 the Social Security Act (42 U.S.C.
13 1395kk(e)(4)(B)(iii)).

14 (2) ACCESS TO CERTAIN DATA.—

15 (A) ACCESS.—To the extent consistent
16 with applicable information, privacy, security,
17 and disclosure laws (including paragraph (3)),
18 notwithstanding paragraph (4)(B) of section
19 1874(e) of the Social Security Act (42 U.S.C.
20 1395kk(e)) and the second sentence of para-
21 graph (4)(D) of such section, beginning July 1,
22 2015, a qualified entity may—

23 (i) provide or sell the combined data
24 described in paragraph (4)(B)(iii) of such
25 section to authorized users described in

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

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

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

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

21 (3) PROTECTION OF INFORMATION.—

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

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

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

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

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

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

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

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

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

1 activities but shall not make public such anal-
2 ysis or data or any analysis using such data.

3 (6) OPPORTUNITY FOR PROVIDERS OF SERV-
4 ICES AND SUPPLIERS TO REVIEW.—Prior to a quali-
5 fied entity providing or selling an analysis to an au-
6 thorized user under paragraph (1), to the extent
7 that such analysis would individually identify a pro-
8 vider of services or supplier who is not being pro-
9 vided or sold such analysis, such qualified entity
10 shall provide such provider or supplier with the op-
11 portunity to appeal and correct errors in the manner
12 described in section 1874(e)(4)(C)(ii) of the Social
13 Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

14 (7) ASSESSMENT FOR A BREACH.—

15 (A) IN GENERAL.—In the case of a breach
16 of a data use agreement under this section or
17 section 1874(e) of the Social Security Act (42
18 U.S.C. 1395kk(e)), the Secretary shall impose
19 an assessment on the qualified entity both in
20 the case of—

21 (i) an agreement between the Sec-
22 retary and a qualified entity; and

23 (ii) an agreement between a qualified
24 entity and an authorized user.

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

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

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

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

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

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

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

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

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

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

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

18 (i) A provider of services.

19 (ii) A supplier.

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

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

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

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

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

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

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

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

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

4 (1) ACCESS.—

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

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

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

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

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

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

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

23 (2) in paragraph (3)—

24 (A) by inserting after the first sentence the
25 following new sentence: “Beginning July 1,

1 2015, if the Secretary determines appropriate,
2 the data described in this paragraph may also
3 include standardized extracts (as determined by
4 the Secretary) of claims data under titles XIX
5 and XXI for assistance provided under such ti-
6 tles for one or more specified geographic areas
7 and time periods requested by a qualified enti-
8 ty.”; and

9 (B) in the last sentence, by inserting “or
10 under titles XIX or XXI” before the period at
11 the end.

12 (d) REVISION OF PLACEMENT OF FEES.—Section
13 1874(e)(4)(A) of the Social Security Act (42 U.S.C.
14 1395kk(e)(4)(A)) is amended, in the second sentence—

15 (1) by inserting “, for periods prior to July 1,
16 2015,” after “deposited”; and

17 (2) by inserting the following before the period
18 at the end: “, and, beginning July 1, 2015, into the
19 Centers for Medicare & Medicaid Services Program
20 Management Account”.

21 **SEC. 108. REDUCING ADMINISTRATIVE BURDEN AND**
22 **OTHER PROVISIONS.**

23 (a) MEDICARE PHYSICIAN AND PRACTITIONER OPT-
24 OUT TO PRIVATE CONTRACT.—

1 (1) INDEFINITE, CONTINUING AUTOMATIC EX-
2 TENSION OF OPT OUT ELECTION.—

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

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

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

15 (iii) by adding at the end the fol-
16 lowing new subparagraph:

17 “(D) APPLICABLE 2-YEAR PERIODS FOR
18 EFFECTIVENESS OF AFFIDAVITS.—In this sub-
19 section, the term ‘applicable 2-year period’
20 means, with respect to an affidavit of a physi-
21 cian or practitioner under subparagraph (B),
22 the 2-year period beginning on the date the af-
23 fidavit is signed and includes each subsequent
24 2-year period unless the physician or practi-
25 tioner involved provides notice to the Secretary

1 (in a form and manner specified by the Sec-
2 retary), not later than 30 days before the end
3 of the previous 2-year period, that the physician
4 or practitioner does not want to extend the ap-
5 plication of the affidavit for such subsequent 2-
6 year period.”.

7 (B) EFFECTIVE DATE.—The amendments
8 made by subparagraph (A) shall apply to affi-
9 davits entered into on or after the date that is
10 60 days after the date of the enactment of this
11 Act.

12 (2) PUBLIC AVAILABILITY OF INFORMATION ON
13 OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section
14 1802(b) of the Social Security Act (42 U.S.C.
15 1395a(b)) is amended—

16 (A) in paragraph (5), by adding at the end
17 the following new subparagraph:

18 “(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—
19 The term ‘opt-out physician or practitioner’ means
20 a physician or practitioner who has in effect an affi-
21 davit under paragraph (3)(B).”;

22 (B) by redesignating paragraph (5) as
23 paragraph (6); and

24 (C) by inserting after paragraph (4) the
25 following new paragraph:

1 “(5) POSTING OF INFORMATION ON OPT-OUT
2 PHYSICIANS AND PRACTITIONERS.—

3 “(A) IN GENERAL.—Beginning not later
4 than February 1, 2015, the Secretary shall
5 make publicly available through an appropriate
6 publicly accessible website of the Department of
7 Health and Human Services information on the
8 number and characteristics of opt-out physi-
9 cians and practitioners and shall update such
10 information on such website not less often than
11 annually.

12 “(B) INFORMATION TO BE INCLUDED.—
13 The information to be made available under
14 subparagraph (A) shall include at least the fol-
15 lowing with respect to opt-out physicians and
16 practitioners:

17 “(i) Their number.

18 “(ii) Their physician or professional
19 specialty or other designation.

20 “(iii) Their geographic distribution.

21 “(iv) The timing of their becoming
22 opt-out physicians and practitioners, rel-
23 ative to when they first entered practice
24 and with respect to applicable 2-year peri-
25 ods.

1 “(v) The proportion of such physi-
2 cians and practitioners who billed for
3 emergency or urgent care services.”.

4 (b) GAINSHARING STUDY AND REPORT.—Not later
5 than 6 months after the date of the enactment of this Act,
6 the Secretary of Health and Human Services, in consulta-
7 tion with the Inspector General of the Department of
8 Health and Human Services, shall submit to Congress a
9 report with legislative recommendations to amend existing
10 fraud and abuse laws, through exceptions, safe harbors,
11 or other narrowly targeted provisions, to permit
12 gainsharing or similar arrangements between physicians
13 and hospitals that improve care while reducing waste and
14 increasing efficiency. The report shall—

15 (1) consider whether such provisions should
16 apply to ownership interests, compensation arrange-
17 ments, or other relationships;

18 (2) describe how the recommendations address
19 accountability, transparency, and quality, including
20 how best to limit inducements to stint on care, dis-
21 charge patients prematurely, or otherwise reduce or
22 limit medically necessary care; and

23 (3) consider whether a portion of any savings
24 generated by such arrangements should accrue to

1 the Medicare program under title XVIII of the So-
2 cial Security Act.

3 (c) PROMOTING INTEROPERABILITY OF ELECTRONIC
4 HEALTH RECORD SYSTEMS.—

5 (1) RECOMMENDATIONS FOR ACHIEVING WIDE-
6 SPREAD EHR INTEROPERABILITY.—

7 (A) OBJECTIVE.—As a consequence of a
8 significant Federal investment in the implemen-
9 tation of health information technology through
10 the Medicare and Medicaid EHR incentive pro-
11 grams, Congress declares it a national objective
12 to achieve widespread exchange of health infor-
13 mation through interoperable certified EHR
14 technology nationwide by December 31, 2017.

15 (B) DEFINITIONS.—In this paragraph:

16 (i) WIDESPREAD INTEROPER-
17 ABILITY.—The term “widespread inter-
18 operability” means interoperability between
19 certified EHR technology systems em-
20 ployed by meaningful EHR users under
21 the Medicare and Medicaid EHR incentive
22 programs and other clinicians and health
23 care providers on a nationwide basis.

24 (ii) INTEROPERABILITY.—The term
25 “interoperability” means the ability of two

1 or more health information systems or
2 components to exchange clinical and other
3 information and to use the information
4 that has been exchanged using common
5 standards as to provide access to longitu-
6 dinal information for health care providers
7 in order to facilitate coordinated care and
8 improved patient outcomes.

9 (C) ESTABLISHMENT OF METRICS.—Not
10 later than July 1, 2015, and in consultation
11 with stakeholders, the Secretary shall establish
12 metrics to be used to determine if and to the
13 extent that the objective described in subpara-
14 graph (A) has been achieved.

15 (D) RECOMMENDATIONS IF OBJECTIVE
16 NOT ACHIEVED.—If the Secretary of Health
17 and Human Services determines that the objec-
18 tive described in subparagraph (A) has not been
19 achieved by December 31, 2017, then the Sec-
20 retary shall submit to Congress a report, by not
21 later than December 31, 2018, that identifies
22 barriers to such objective and recommends ac-
23 tions that the Federal Government can take to
24 achieve such objective. Such recommended ac-
25 tions may include recommendations—

1 (i) to adjust payments for not being
2 meaningful EHR users under the Medicare
3 EHR incentive programs; and

4 (ii) for criteria for decertifying cer-
5 tified EHR technology products.

6 (2) PREVENTING BLOCKING THE SHARING OF
7 INFORMATION.—

8 (A) FOR MEANINGFUL EHR PROFES-
9 SIONALS.—Section 1848(o)(2)(A)(ii) of the So-
10 cial Security Act (42 U.S.C. 1395w-
11 4(o)(2)(A)(ii)) is amended by inserting before
12 the period at the end the following: “, and the
13 professional demonstrates (through a process
14 specified by the Secretary, such as the use of an
15 attestation) that the professional has not know-
16 ingly and willfully taken any action to limit or
17 restrict the compatibility or interoperability of
18 the certified EHR technology”.

19 (B) FOR MEANINGFUL EHR HOSPITALS.—
20 Section 1886(n)(3)(A)(ii) of the Social Security
21 Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amend-
22 ed by inserting before the period at the end the
23 following: “, and the hospital demonstrates
24 (through a process specified by the Secretary,
25 such as the use of an attestation) that the hos-

1 pital has not knowingly and willfully taken any
2 action to limit or restrict the compatibility or
3 interoperability of the certified EHR tech-
4 nology”.

5 (C) EFFECTIVE DATE.—The amendments
6 made by this subsection shall apply to meaning-
7 ful EHR users as of the date that is one year
8 after the date of the enactment of this Act.

9 (3) STUDY AND REPORT ON THE FEASIBILITY
10 OF ESTABLISHING A WEBSITE TO COMPARE CER-
11 TIFIED EHR TECHNOLOGY PRODUCTS.—

12 (A) STUDY.—The Secretary shall conduct
13 a study to examine the feasibility of estab-
14 lishing mechanisms that includes aggregated re-
15 sults of surveys of meaningful EHR users on
16 the functionality of certified EHR technology
17 products to enable such users to directly com-
18 pare the functionality and other features of
19 such products. Such information may be made
20 available through contracts with physician, hos-
21 pital, or other organizations that maintain such
22 comparative information.

23 (B) REPORT.—Not later than 1 year after
24 the date of the enactment of this Act, the Sec-
25 retary shall submit to Congress a report on the

1 website. The report shall include information on
2 the benefits of, and resources needed to develop
3 and maintain, such a website.

4 (4) DEFINITIONS.—In this subsection:

5 (A) The term “certified EHR technology”
6 has the meaning given such term in section
7 1848(o)(4) of the Social Security Act (42
8 U.S.C. 1395w-4(o)(4)).

9 (B) The term “meaningful EHR user” has
10 the meaning given such term under the Medi-
11 care EHR incentive programs.

12 (C) The term “Medicare and Medicaid
13 EHR incentive programs” means—

14 (i) in the case of the Medicare pro-
15 gram under title XVIII of the Social Secu-
16 rity Act, the incentive programs under sec-
17 tion 1814(l)(3), section 1848(o), sub-
18 sections (l) and (m) of section 1853, and
19 section 1886(n) of the Social Security Act
20 (42 U.S.C. 1395f(l)(3), 1395w-4(o),
21 1395w-23, 1395ww(n)); and

22 (ii) in the case of the Medicaid pro-
23 gram under title XIX of such Act, the in-
24 centive program under subsections

1 (a)(3)(F) and (t) of section 1903 of such
2 Act (42 U.S.C. 1396b).

3 (D) The term “Secretary” means the Sec-
4 retary of Health and Human Services.

5 (d) GAO STUDIES AND REPORTS ON THE USE OF
6 TELEHEALTH UNDER FEDERAL PROGRAMS AND ON RE-
7 MOTE PATIENT MONITORING SERVICES.—

8 (1) STUDY ON TELEHEALTH SERVICES.—The
9 Comptroller General of the United States shall con-
10 duct a study on the following:

11 (A) How the definition of telehealth across
12 various Federal programs and Federal efforts
13 can inform the use of telehealth in the Medicare
14 program under title XVIII of the Social Secu-
15 rity Act (42 U.S.C. 1395 et seq.).

16 (B) Issues that can facilitate or inhibit the
17 use of telehealth under the Medicare program
18 under such title, including oversight and profes-
19 sional licensure, changing technology, privacy
20 and security, infrastructure requirements, and
21 varying needs across urban and rural areas.

22 (C) Potential implications of greater use of
23 telehealth with respect to payment and delivery
24 system transformations under the Medicare
25 program under such title XVIII and the Med-

1 icaid program under title XIX of such Act (42
2 U.S.C. 1396 et seq.).

3 (D) How the Centers for Medicare & Med-
4 icaid Services conducts oversight of payments
5 made under the Medicare program under such
6 title XVIII to providers for telehealth services.

7 (2) STUDY ON REMOTE PATIENT MONITORING
8 SERVICES.—

9 (A) IN GENERAL.—The Comptroller Gen-
10 eral of the United States shall conduct a
11 study—

12 (i) of the dissemination of remote pa-
13 tient monitoring technology in the private
14 health insurance market;

15 (ii) of the financial incentives in the
16 private health insurance market relating to
17 adoption of such technology;

18 (iii) of the barriers to adoption of
19 such services under the Medicare program
20 under title XVIII of the Social Security
21 Act;

22 (iv) that evaluates the patients, condi-
23 tions, and clinical circumstances that could
24 most benefit from remote patient moni-
25 toring services; and

1 (v) that evaluates the challenges re-
2 lated to establishing appropriate valuation
3 for remote patient monitoring services
4 under the Medicare physician fee schedule
5 under section 1848 of the Social Security
6 Act (42 U.S.C. 1395w-4) in order to accu-
7 rately reflect the resources involved in fur-
8 nishing such services.

9 (B) DEFINITIONS.—For purposes of this
10 paragraph:

11 (i) REMOTE PATIENT MONITORING
12 SERVICES.—The term “remote patient
13 monitoring services” means services fur-
14 nished through remote patient monitoring
15 technology.

16 (ii) REMOTE PATIENT MONITORING
17 TECHNOLOGY.—The term “remote patient
18 monitoring technology” means a coordi-
19 nated system that uses one or more home-
20 based or mobile monitoring devices that
21 automatically transmit vital sign data or
22 information on activities of daily living and
23 may include responses to assessment ques-
24 tions collected on the devices wirelessly or
25 through a telecommunications connection

1 to a server that complies with the Federal
2 regulations (concerning the privacy of indi-
3 vidually identifiable health information)
4 promulgated under section 264(c) of the
5 Health Insurance Portability and Account-
6 ability Act of 1996, as part of an estab-
7 lished plan of care for that patient that in-
8 cludes the review and interpretation of that
9 data by a health care professional.

10 (3) REPORTS.—Not later than 24 months after
11 the date of the enactment of this Act, the Comp-
12 troller General shall submit to Congress—

13 (A) a report containing the results of the
14 study conducted under paragraph (1); and

15 (B) a report containing the results of the
16 study conducted under paragraph (2).

17 A report required under this paragraph shall be sub-
18 mitted together with recommendations for such leg-
19 islation and administrative action as the Comptroller
20 General determines appropriate. The Comptroller
21 General may submit one report containing the re-
22 sults described in subparagraphs (A) and (B) and
23 the recommendations described in the previous sen-
24 tence.

1 (e) RULE OF CONSTRUCTION REGARDING
2 HEALTHCARE PROVIDER STANDARDS OF CARE.—

3 (1) MAINTENANCE OF STATE STANDARDS.—

4 The development, recognition, or implementation of
5 any guideline or other standard under any Federal
6 health care provision shall not be construed—

7 (A) to establish the standard of care or
8 duty of care owed by a health care provider to
9 a patient in any medical malpractice or medical
10 product liability action or claim; or

11 (B) to preempt any standard of care or
12 duty of care, owed by a health care provider to
13 a patient, duly established under State or com-
14 mon law.

15 (2) DEFINITIONS.—For purposes of this sub-
16 section:

17 (A) FEDERAL HEALTH CARE PROVISION.—

18 The term “Federal health care provision”
19 means any provision of the Patient Protection
20 and Affordable Care Act (Public Law 111–
21 148), title I or subtitle B of title II of the
22 Health Care and Education Reconciliation Act
23 of 2010 (Public Law 111–152), or title XVIII
24 or XIX of the Social Security Act.

1 (B) HEALTH CARE PROVIDER.—The term
2 “health care provider” means any individual or
3 entity—

4 (i) licensed, registered, or certified
5 under Federal or State laws or regulations
6 to provide health care services; or

7 (ii) required to be so licensed, reg-
8 istered, or certified but that is exempted
9 by other statute or regulation.

10 (C) MEDICAL MALPRACTICE OR MEDICAL
11 PRODUCT LIABILITY ACTION OR CLAIM.—The
12 term “medical malpractice or medical product
13 liability action or claim” means a medical mal-
14 practice action or claim (as defined in section
15 431(7) of the Health Care Quality Improve-
16 ment Act of 1986 (42 U.S.C. 11151(7))) and
17 includes a liability action or claim relating to a
18 health care provider’s prescription or provision
19 of a drug, device, or biological product (as such
20 terms are defined in section 201 of the Federal
21 Food, Drug, and Cosmetic Act or section 351
22 of the Public Health Service Act).

23 (D) STATE.—The term “State” includes
24 the District of Columbia, Puerto Rico, and any

1 other commonwealth, possession, or territory of
2 the United States.

3 (3) PRESERVATION OF STATE LAW.—No provi-
4 sion of the Patient Protection and Affordable Care
5 Act (Public Law 111–148), title I or subtitle B of
6 title II of the Health Care and Education Reconcili-
7 ation Act of 2010 (Public Law 111–152), or title
8 XVIII or XIX of the Social Security Act shall be
9 construed to preempt any State or common law gov-
10 erning medical professional or medical product liabil-
11 ity actions or claims.

12 **TITLE II—EXTENSIONS**

13 **Subtitle A—Medicare Extensions**

14 **SEC. 201. WORK GEOGRAPHIC ADJUSTMENT.**

15 Section 1848(e)(1)(E) of the Social Security Act (42
16 U.S.C. 1395w–4(e)(1)(E)) is amended by striking “and
17 before April 1, 2014,”.

18 **SEC. 202. MEDICARE PAYMENT FOR THERAPY SERVICES.**

19 (a) REPEAL OF THERAPY CAP AND 1-YEAR EXTEN-
20 SION OF THRESHOLD FOR MANUAL MEDICAL REVIEW.—
21 Section 1833(g) of the Social Security Act (42 U.S.C.
22 1395l(g)) is amended—

23 (1) in paragraph (4)—

1 (A) by striking “This subsection” and in-
2 serting “Except as provided in paragraph
3 (5)(C)(iii), this subsection”; and

4 (B) by inserting the following before the
5 period at the end: “or with respect to services
6 furnished on or after the date of enactment of
7 the Responsible Medicare SGR Repeal and Ben-
8 eficiary Access Improvement Act of 2014”; and
9 (2) in paragraph (5)(C), by adding at the end
10 the following new clause:

11 “(iii) Beginning on the date of enactment of the Re-
12 sponsible Medicare SGR Repeal and Beneficiary Access
13 Improvement Act of 2014 and ending on the day before
14 the date that is 12 months after such date of enactment,
15 the manual medical review process described in clause (i)
16 shall apply with respect to expenses incurred in a year for
17 services described in paragraphs (1) and (3) that exceed
18 the threshold described in clause (ii) for the year.”.

19 (b) MEDICAL REVIEW OF OUTPATIENT THERAPY
20 SERVICES.—

21 (1) MEDICAL REVIEW OF OUTPATIENT THER-
22 APY SERVICES.—Section 1833 of the Social Security
23 Act (42 U.S.C. 1395l), as amended by section
24 101(e)(2), is amended by adding at the end the fol-
25 lowing new subsection:

1 “(aa) MEDICAL REVIEW OF OUTPATIENT THERAPY
2 SERVICES.—

3 “(1) IN GENERAL.—

4 “(A) PROCESS FOR MEDICAL REVIEW.—

5 The Secretary shall implement a process for the
6 medical review (as described in paragraph (2))
7 of outpatient therapy services (as defined in
8 paragraph (10)) and, subject to paragraph
9 (12), apply such process to such services fur-
10 nished on or after the date that is 12 months
11 after the date of enactment of the Responsible
12 Medicare SGR Repeal and Beneficiary Access
13 Improvement Act of 2014, focusing on services
14 identified under subparagraph (B).

15 “(B) IDENTIFICATION OF SERVICES FOR
16 REVIEW.—Under the process, the Secretary
17 shall identify services for medical review, using
18 such factors as the Secretary determines appro-
19 priate, which may include the following:

20 “(i) Services furnished by a therapy
21 provider (as defined in paragraph (10))
22 whose pattern of billing is aberrant com-
23 pared to peers.

24 “(ii) Services furnished by a therapy
25 provider who, in a prior period, has a high

1 claims denial percentage or is less compli-
2 ant with other applicable requirements
3 under this title.

4 “(iii) Services furnished by a therapy
5 provider that is newly enrolled under this
6 title.

7 “(iv) Services furnished by a therapy
8 provider who has questionable billing prac-
9 tices, such as billing medically unlikely
10 units of services in a day.

11 “(v) Services furnished to treat a type
12 of medical condition.

13 “(vi) Services identified by use of the
14 standardized data elements required to be
15 reported under section 1834(p).

16 “(vii) Services furnished by a single
17 therapy provider or a group that includes
18 a therapy provider identified by factors de-
19 scribed in this subparagraph.

20 “(viii) Other services as determined
21 appropriate by the Secretary.

22 “(2) MEDICAL REVIEW.—

23 “(A) PRIOR AUTHORIZATION MEDICAL RE-
24 VIEW.—

1 “(i) IN GENERAL.—Subject to the
2 succeeding provisions of this subparagraph,
3 the Secretary shall use prior authorization
4 medical review for outpatient therapy serv-
5 ices furnished to an individual above one
6 or more thresholds established by the Sec-
7 retary, such as a dollar threshold or a
8 threshold based on other factors.

9 “(ii) ENDING APPLICATION OF PRIOR
10 AUTHORIZATION FOR A THERAPY PRO-
11 VIDER.—The Secretary shall end the appli-
12 cation of prior authorization medical re-
13 view to outpatient therapy services fur-
14 nished by a therapy provider if the Sec-
15 retary determines that the provider has a
16 low denial rate under such prior authoriza-
17 tion. The Secretary may subsequently re-
18 apply prior authorization medical review to
19 such therapy provider if the Secretary de-
20 termines it to be appropriate.

21 “(iii) PRIOR AUTHORIZATION OF MUL-
22 TIPLE SERVICES.—The Secretary shall,
23 where practicable, provide for prior author-
24 ization medical review for multiple services
25 at a single time, such as services in a ther-

1 apy plan of care described in section
2 1861(p)(2).

3 “(B) OTHER TYPES OF MEDICAL RE-
4 VIEW.—The Secretary may use pre-payment re-
5 view or post-payment review for services identi-
6 fied under paragraph (1)(B) that are not sub-
7 ject to prior authorization medical review under
8 subparagraph (A).

9 “(C) LIMITATION FOR LAW ENFORCEMENT
10 ACTIVITIES.—The Secretary may determine
11 that medical review under this subsection does
12 not apply in the case where potential fraud may
13 be involved.

14 “(3) REVIEW CONTRACTORS.—The Secretary
15 shall conduct prior authorization medical review of
16 outpatient therapy services under this subsection
17 using medicare administrative contractors (as de-
18 scribed in section 1874A) or other review contrac-
19 tors (other than contractors under section 1893(h)
20 or contractors paid on a contingent basis).

21 “(4) NO PAYMENT WITHOUT PRIOR AUTHORIZA-
22 TION.—With respect to an outpatient therapy service
23 for which prior authorization medical review under
24 this subsection applies, the following shall apply:

1 “(A) PRIOR AUTHORIZATION DETERMINA-
2 TION.—The Secretary shall make a determina-
3 tion, prior to the service being furnished, of
4 whether the service would or would not meet
5 the applicable requirements of section
6 1862(a)(1)(A).

7 “(B) DENIAL OF PAYMENT.—Subject to
8 paragraph (6), no payment shall be made under
9 this part for the service unless the Secretary
10 determines pursuant to subparagraph (A) that
11 the service would meet the applicable require-
12 ments of such section.

13 “(5) SUBMISSION OF INFORMATION.—A ther-
14 apy provider may submit the information necessary
15 for medical review by fax, by mail, or by electronic
16 means. The Secretary shall make available the elec-
17 tronic means described in the preceding sentence as
18 soon as practicable, but not later than 24 months
19 after the date of enactment of this subsection.

20 “(6) TIMELINESS.—If the Secretary does not
21 make a prior authorization determination under
22 paragraph (4)(A) within 10 business days of the
23 date of the Secretary’s receipt of medical docu-
24 mentation needed to make such determination, para-
25 graph (4)(B) shall not apply.

1 “(7) CONSTRUCTION.—With respect to an out-
2 patient therapy service that has been affirmed by
3 medical review under this subsection, nothing in this
4 subsection shall be construed to preclude the subse-
5 quent denial of a claim for such service that does
6 not meet other applicable requirements under this
7 Act.

8 “(8) BENEFICIARY PROTECTIONS.—With re-
9 spect to services furnished on or after January 1,
10 2015, where payment may not be made as a result
11 of application of medical review under this sub-
12 section, section 1879 shall apply in the same manner
13 as such section applies to a denial that is made by
14 reason of section 1862(a)(1).

15 “(9) IMPLEMENTATION.—

16 “(A) AUTHORITY.—The Secretary may im-
17 plement the provisions of this subsection by in-
18 terim final rule with comment period.

19 “(B) ADMINISTRATION.—Chapter 35 of
20 title 44, United States Code, shall not apply to
21 medical review under this subsection.

22 “(C) LIMITATION.—There shall be no ad-
23 ministrative or judicial review under section
24 1869, section 1878, or otherwise of the identi-
25 fication of services for medical review or the

1 process for medical review under this sub-
2 section.

3 “(10) DEFINITIONS.—For purposes of this sub-
4 section:

5 “(A) OUTPATIENT THERAPY SERVICES.—
6 The term ‘outpatient therapy services’ means
7 the following services for which payment is
8 made under section 1848, 1834(g), or 1834(k):

9 “(i) Physical therapy services of the
10 type described in section 1861(p).

11 “(ii) Speech-language pathology serv-
12 ices of the type described in such section
13 though the application of section
14 1861(ll)(2).

15 “(iii) Occupational therapy services of
16 the type described in section 1861(p)
17 through the operation of section 1861(g).

18 “(B) THERAPY PROVIDER.—The term
19 ‘therapy provider’ means a provider of services
20 (as defined in section 1861(u)) or a supplier (as
21 defined in section 1861(d)) who submits a claim
22 for outpatient therapy services.

23 “(11) FUNDING.—For purposes of imple-
24 menting this subsection, the Secretary shall provide
25 for the transfer, from the Federal Supplementary

1 Medical Insurance Trust Fund under section 1841,
2 of \$35,000,000 to the Centers for Medicare & Med-
3 icaid Services Program Management Account for
4 each fiscal year (beginning with fiscal year 2014).
5 Amounts transferred under this paragraph shall re-
6 main available until expended.

7 “(12) SCALING BACK.—

8 “(A) PERIODIC DETERMINATIONS.—Begin-
9 ning with 2017, and every two years thereafter,
10 the Secretary shall—

11 “(i) make a determination of the im-
12 proper payment rate for outpatient therapy
13 services for a 12-month period; and

14 “(ii) make such determination publicly
15 available.

16 “(B) SCALING BACK.—If the improper
17 payment rate for outpatient therapy services de-
18 termined for a 12-month period under subpara-
19 graph (A) is 50 percent or less of the Medicare
20 fee-for-service improper payment rate for such
21 period, the Secretary shall—

22 “(i) reduce the amount and extent of
23 medical review conducted for a prospective
24 year under the process established in this
25 subsection; and

1 “(ii) return an appropriate portion of
2 the funding provided for such year under
3 paragraph (11).”.

4 (2) GAO STUDY AND REPORT.—

5 (A) STUDY.—The Comptroller General of
6 the United States shall conduct a study on the
7 effectiveness of medical review of outpatient
8 therapy services under section 1833(aa) of the
9 Social Security Act, as added by paragraph (1).
10 Such study shall include an analysis of—

11 (i) aggregate data on—

12 (I) the number of individuals,
13 therapy providers, and claims subject
14 to such review; and

15 (II) the number of reviews con-
16 ducted under such section; and

17 (ii) the outcomes of such reviews.

18 (B) REPORT.—Not later than 3 years after
19 the date of enactment of this Act, the Comp-
20 troller General shall submit to Congress a re-
21 port containing the results of the study under
22 subparagraph (A), together with recommenda-
23 tions for such legislation and administrative ac-
24 tion as the Comptroller General determines ap-
25 propriate.

1 (c) COLLECTION OF STANDARDIZED DATA ELE-
2 MENTS FOR OUTPATIENT THERAPY SERVICES.—

3 (1) COLLECTION OF STANDARDIZED DATA ELE-
4 MENTS FOR OUTPATIENT THERAPY SERVICES.—Sec-
5 tion 1834 of the Social Security Act (42 U.S.C.
6 1395m) is amended by adding at the end the fol-
7 lowing new subsection:

8 “(p) COLLECTION OF STANDARDIZED DATA ELE-
9 MENTS FOR OUTPATIENT THERAPY SERVICES.—

10 “(1) STANDARDIZED DATA ELEMENTS.—

11 “(A) IN GENERAL.—Not later than 6
12 months after the date of enactment of this sub-
13 section, the Secretary shall post on the Internet
14 website of the Centers for Medicare & Medicaid
15 Services a draft list of standardized data ele-
16 ments for individuals receiving outpatient ther-
17 apy services.

18 “(B) DOMAINS.—Such standardized data
19 elements shall include information with respect
20 to the following domains, as determined appro-
21 priate by the Secretary:

22 “(i) Demographic information.

23 “(ii) Diagnosis.

24 “(iii) Severity.

1 “(iv) Affected body structures and
2 functions.

3 “(v) Limitations with activities of
4 daily living and participation.

5 “(vi) Functional status.

6 “(vii) Other domains determined to be
7 appropriate by the Secretary.

8 “(C) SOLICITATION OF INPUT.—The Sec-
9 retary shall accept comments from stakeholders
10 through the date that is 60 days after the date
11 the Secretary posts the draft list of standard-
12 ized data elements pursuant to subparagraph
13 (A). In seeking such comments, the Secretary
14 shall use one or more mechanisms to solicit
15 input from stakeholders that may include use of
16 open door forums, town hall meetings, requests
17 for information, or other mechanisms deter-
18 mined appropriate by the Secretary.

19 “(D) OPERATIONAL LIST OF STANDARD-
20 IZED DATA ELEMENTS.—Not later than 120
21 days after the end of the comment period de-
22 scribed in subparagraph (C), the Secretary, tak-
23 ing into account such comments, shall post on
24 the Internet website of the Centers for Medi-

1 care & Medicaid Services an operational list of
2 standardized data elements.

3 “(E) SUBSEQUENT REVISIONS.—Subse-
4 quent revisions to the operational list of stand-
5 ardized data elements shall be made through
6 rulemaking. Such revisions may be based on ex-
7 perience and input from stakeholders.

8 “(2) SYSTEM TO REPORT STANDARDIZED DATA
9 ELEMENTS.—

10 “(A) IN GENERAL.—Not later than 18
11 months after the date the Secretary posts the
12 operational list of standardized data elements
13 pursuant to paragraph (1)(D), the Secretary
14 shall develop and implement an electronic sys-
15 tem (which may be a web portal) for therapy
16 providers to report the standardized data ele-
17 ments for individuals with respect to outpatient
18 therapy services.

19 “(B) CONSULTATION.—The Secretary
20 shall seek comments from stakeholders regard-
21 ing the best way to report the standardized
22 data elements.

23 “(3) REPORTING.—

24 “(A) FREQUENCY OF REPORTING.—The
25 Secretary shall specify the frequency of report-

1 ing standardized data elements. The Secretary
2 shall seek comments from stakeholders regard-
3 ing the frequency of the reporting of such data
4 elements.

5 “(B) REPORTING REQUIREMENT.—Begin-
6 ning on the date the system to report standard-
7 ized data elements under this subsection is
8 operational, no payment shall be made under
9 this part for outpatient therapy services fur-
10 nished to an individual unless a therapy pro-
11 vider reports the standardized data elements for
12 such individual.

13 “(4) REPORT ON NEW PAYMENT SYSTEM FOR
14 OUTPATIENT THERAPY SERVICES.—

15 “(A) IN GENERAL.—Not later than 24
16 months after the date described in paragraph
17 (3)(B), the Secretary shall submit to Congress
18 a report on the design of a new payment system
19 for outpatient therapy services. The report shall
20 include an analysis of the standardized data ele-
21 ments collected and other appropriate data and
22 information.

23 “(B) FEATURES.—Such report shall con-
24 sider—

1 “(i) appropriate adjustments to pay-
2 ment (such as case mix and outliers);

3 “(ii) payments on an episode of care
4 basis; and

5 “(iii) reduced payment for multiple
6 episodes.

7 “(C) CONSULTATION.—The Secretary shall
8 consult with stakeholders regarding the design
9 of such a new payment system.

10 “(5) IMPLEMENTATION.—

11 “(A) FUNDING.—For purposes of imple-
12 menting this subsection, the Secretary shall
13 provide for the transfer, from the Federal Sup-
14 plementary Medical Insurance Trust Fund
15 under section 1841, of \$7,000,000 to the Cen-
16 ters for Medicare & Medicaid Services Program
17 Management Account for each of fiscal years
18 2014 through 2018. Amounts transferred under
19 this subparagraph shall remain available until
20 expended.

21 “(B) ADMINISTRATION.—Chapter 35 of
22 title 44, United States Code, shall not apply to
23 specification of the standardized data elements
24 and implementation of the system to report

1 such standardized data elements under this
2 subsection.

3 “(C) LIMITATION.—There shall be no ad-
4 ministrative or judicial review under section
5 1869, section 1878, or otherwise of the speci-
6 fication of standardized data elements required
7 under this subsection or the system to report
8 such standardized data elements.

9 “(D) DEFINITION OF OUTPATIENT THER-
10 APY SERVICES AND THERAPY PROVIDER.—In
11 this subsection, the terms ‘outpatient therapy
12 services’ and ‘therapy provider’ have the mean-
13 ing given those term in section 1833(aa).”.

14 (2) SUNSET OF CURRENT CLAIMS-BASED COL-
15 LECTION OF THERAPY DATA.—Section 3005(g)(1) of
16 the Middle Class Tax Extension and Job Creation
17 Act of 2012 (42 U.S.C. 1395l note) is amended, in
18 the first sentence, by inserting “and ending on the
19 date the system to report standardized data ele-
20 ments under section 1834(p) of the Social Security
21 Act (42 U.S.C. 1395m(p)) is implemented,” after
22 “January 1, 2013,”.

23 (d) REPORTING OF CERTAIN INFORMATION.—Sec-
24 tion 1842(t) of the Social Security Act (42 U.S.C.

1 1395u(t)) is amended by adding at the end the following
2 new paragraph:

3 “(3) Each request for payment, or bill submitted, by
4 a therapy provider (as defined in section 1833(aa)(10))
5 for an outpatient therapy service (as defined in such sec-
6 tion) furnished by a therapy assistant on or after January
7 1, 2015, shall include (in a form and manner specified
8 by the Secretary) an indication that the service was fur-
9 nished by a therapy assistant.”.

10 **SEC. 203. MEDICARE AMBULANCE SERVICES.**

11 (a) **EXTENSION OF CERTAIN AMBULANCE ADD-ON**
12 **PAYMENTS.—**

13 (1) **GROUND AMBULANCE.—**Section
14 1834(l)(13)(A) of the Social Security Act (42 U.S.C.
15 1395m(l)(13)(A)) is amended by striking “April 1,
16 2014” and inserting “January 1, 2019” each place
17 it appears.

18 (2) **SUPER RURAL AMBULANCE.—**Section
19 1834(l)(12)(A) of the Social Security Act (42 U.S.C.
20 1395m(l)(12)(A)) is amended, in the first sentence,
21 by striking “April 1, 2014” and inserting “January
22 1, 2019”.

23 (b) **REQUIRING AMBULANCE PROVIDERS TO SUBMIT**
24 **COST AND OTHER INFORMATION.—**Section 1834(l) of the

1 Social Security Act (42 U.S.C. 1395m(l)) is amended by
2 adding at the end the following new paragraph:

3 “(16) SUBMISSION OF COST AND OTHER INFOR-
4 MATION.—

5 “(A) DEVELOPMENT OF DATA COLLECTION
6 SYSTEM.—The Secretary shall develop a data
7 collection system (which may include use of a
8 cost survey and standardized definitions) for
9 providers and suppliers of ambulance services to
10 collect cost, revenue, utilization, and other in-
11 formation determined appropriate by the Sec-
12 retary. Such system shall be designed to submit
13 information—

14 “(i) needed to evaluate the appro-
15 priateness of payment rates under this
16 subsection;

17 “(ii) on the utilization of capital
18 equipment and ambulance capacity; and

19 “(iii) on different types of ambulance
20 services furnished in different geographic
21 locations, including rural areas and low
22 population density areas described in para-
23 graph (12).

24 “(B) SPECIFICATION OF DATA COLLEC-
25 TION SYSTEM.—

1 “(i) IN GENERAL.—Not later than
2 July 1, 2015, the Secretary shall—

3 “(I) specify the data collection
4 system under subparagraph (A) and
5 the time period during which such
6 data is required to be submitted; and

7 “(II) identify the providers and
8 suppliers of ambulance services who
9 would be required to submit the infor-
10 mation under such data collection sys-
11 tem.

12 “(ii) RESPONDENTS.—Subject to sub-
13 paragraph (D)(ii), the Secretary shall de-
14 termine an appropriate sample of providers
15 and suppliers of ambulance services to sub-
16 mit information under the data collection
17 system for each period for which reporting
18 of data is required.

19 “(C) PENALTY FOR FAILURE TO REPORT
20 COST AND OTHER INFORMATION.—Beginning
21 on July 1, 2016, a 5 percent reduction to pay-
22 ments under this part shall be made for a 1-
23 year prospective period specified by the Sec-
24 retary to a provider or supplier of ambulance
25 services who—

1 “(i) is identified under subparagraph
2 (B)(i)(II) as being required to submit the
3 information under the data collection sys-
4 tem; and

5 “(ii) does not submit such information
6 during the period specified under subpara-
7 graph (B)(i)(I).

8 “(D) ONGOING DATA COLLECTION.—

9 “(i) REVISION OF DATA COLLECTION
10 SYSTEM.—The Secretary may, as deter-
11 mined appropriate, periodically revise the
12 data collection system.

13 “(ii) SUBSEQUENT DATA COLLEC-
14 TION.—In order to continue to evaluate
15 the appropriateness of payment rates
16 under this subsection, the Secretary shall,
17 for years after 2016 (but not less often
18 than once every 3 years), require providers
19 and suppliers of ambulance services to sub-
20 mit information for a period the Secretary
21 determines appropriate. The penalty de-
22 scribed in subparagraph (C) shall apply to
23 such subsequent data collection periods.

24 “(E) CONSULTATION.—The Secretary shall
25 consult with stakeholders in carrying out the

1 development of the system and collection of in-
2 formation under this paragraph, including the
3 activities described in subparagraphs (A) and
4 (D). Such consultation shall include the use of
5 requests for information and other mechanisms
6 determined appropriate by the Secretary.

7 “(F) ADMINISTRATION.—Chapter 35 of
8 title 44, United States Code, shall not apply to
9 the collection of information required under this
10 subsection.

11 “(G) LIMITATIONS ON REVIEW.—There
12 shall be no administrative or judicial review
13 under section 1869, section 1878, or otherwise
14 of the data collection system or identification of
15 respondents under this paragraph.

16 “(H) FUNDING FOR IMPLEMENTATION.—
17 For purposes of carrying out subparagraph (A),
18 the Secretary shall provide for the transfer,
19 from the Federal Supplementary Medical Insur-
20 ance Trust Fund under section 1841, of
21 \$1,000,000 to the Centers for Medicare & Med-
22 icaid Services Program Management Account
23 for fiscal year 2014. Amounts transferred under
24 this subparagraph shall remain available until
25 expended.”.

1 **SEC. 204. REVISION OF THE MEDICARE-DEPENDENT HOS-**
2 **PITAL (MDH) PROGRAM.**

3 (a) PERMANENT EXTENSION OF PAYMENT METHOD-
4 OLOGY.—

5 (1) IN GENERAL.—Section 1886(d)(5)(G) of
6 the Social Security Act (42 U.S.C.
7 1395ww(d)(5)(G)) is amended—

8 (A) in clause (i), by striking “and before
9 April 1, 2014,”; and

10 (B) in clause (ii)(II), by striking “and be-
11 fore April 1, 2014,”.

12 (2) CONFORMING AMENDMENTS.—

13 (A) TARGET AMOUNT.—Section
14 1886(b)(3)(D) of the Social Security Act (42
15 U.S.C. 1395ww(b)(3)(D)) is amended—

16 (i) in the matter preceding clause (i),
17 by striking “and before April 1, 2014,”;
18 and

19 (ii) in clause (iv), by striking
20 “through fiscal year 2013 and the portion
21 of fiscal year 2014 before April 1, 2014”
22 and inserting “or a subsequent fiscal
23 year”.

24 (B) HOSPITAL VALUE-BASED PURCHASING
25 PROGRAM.—Section 1886(o)(7)(D)(ii)(I) of the
26 Social Security Act (42 U.S.C.

1 1395ww(o)(7)(D)(ii)(I) is amended by striking
2 “(with respect to discharges occurring during
3 fiscal year 2012 and 2013)”.

4 (C) HOSPITAL READMISSION REDUCTION
5 PROGRAM.—Section 1886(q)(2)(B)(i) of the So-
6 cial Security Act (42 U.S.C.
7 1395ww(q)(2)(B)(i)) is amended by striking
8 “(with respect to discharges occurring during
9 fiscal years 2012 and 2013)”.

10 (D) PERMITTING HOSPITALS TO DECLINE
11 RECLASSIFICATION.—Section 13501(e)(2) of
12 the Omnibus Budget Reconciliation Act of 1993
13 (42 U.S.C. 1395ww note) is amended by strik-
14 ing “fiscal year 1998, fiscal year 1999, or fiscal
15 year 2000 through the first 2 quarters of fiscal
16 year 2014” and inserting “or fiscal year 1998
17 or a subsequent fiscal year”.

18 (b) GAO STUDY AND REPORT ON MEDICARE-DE-
19 PENDENT HOSPITALS.—

20 (1) STUDY.—The Comptroller General of the
21 United States shall conduct a study on the following:

22 (A) The payor mix of medicare-dependent,
23 small rural hospitals (as defined in section
24 1886(d)(5)(G)(iv)), how such mix will trend in
25 future years, and whether or not the require-

1 ment under subclause (IV) of such section
2 should be revised.

3 (B) The characteristics of medicare-de-
4 pendent, small rural hospitals that meet the re-
5 quirement of such subclause (IV) through the
6 application of paragraph (a)(iii)(A) or
7 (a)(iii)(B) of section 412.108 of the Code of
8 Federal Regulations, including Medicare inpa-
9 tient and outpatient utilization, payor mix, and
10 financial status, including Medicare and total
11 margins, and whether or not Medicare pay-
12 ments for such hospitals should be revised.

13 (C) Such other items related to medicare-
14 dependent, small rural hospitals as the Comp-
15 troller General determines appropriate.

16 (2) REPORT.—Not later than 12 months after
17 the date of the enactment of this Act, the Comp-
18 troller General of the United States shall submit to
19 Congress a report on the study conducted under
20 paragraph (1), together with recommendations for
21 such legislation and administrative action as the
22 Comptroller General determines appropriate.

23 (c) IMPLEMENTATION.—Notwithstanding any other
24 provision of law, for purposes of fiscal year 2014, the Sec-
25 retary of Health and Human Services may implement the

1 provisions of, and the amendments made by, this section
2 through program instruction or otherwise.

3 **SEC. 205. REVISION OF MEDICARE INPATIENT HOSPITAL**
4 **PAYMENT ADJUSTMENT FOR LOW-VOLUME**
5 **HOSPITALS.**

6 (a) IN GENERAL.—Section 1886(d)(12) of the Social
7 Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

8 (1) in subparagraph (B)—

9 (A) in the subparagraph heading, by in-
10 sserting “FOR FISCAL YEARS 2005 THROUGH
11 2010” after “INCREASE”; and

12 (B) in the matter preceding clause (i), by
13 striking “and for discharges occurring in the
14 portion of fiscal year 2014 beginning on April
15 1, 2014, fiscal year 2015, and subsequent
16 years”;

17 (2) in subparagraph (C)(i)—

18 (A) by striking “fiscal years 2011, 2012,
19 and 2013, and the portion of fiscal year 2014
20 before” and inserting “fiscal year 2011 and
21 subsequent fiscal years,” each place it appears;
22 and

23 (B) by striking “or portion of fiscal year”
24 after “during the fiscal year”; and

25 (3) in subparagraph (D)—

1 (A) in the heading, by striking “TEM-
2 PORARY APPLICABLE PERCENTAGE INCREASE”
3 and inserting “APPLICABLE PERCENTAGE IN-
4 CREASE FOR FISCAL YEAR 2011 AND SUBSE-
5 QUENT FISCAL YEARS”;

6 (B) by striking “fiscal years 2011, 2012,
7 and 2013, and the portion of fiscal year 2014
8 before April 1, 2014” and inserting “fiscal year
9 2011 or a subsequent fiscal year”; and

10 (C) by striking “or the portion of fiscal
11 year” after “in the fiscal year”.

12 (b) IMPLEMENTATION.—Notwithstanding any other
13 provision of law, for purposes of fiscal year 2014, the Sec-
14 retary of Health and Human Services may implement the
15 provisions of, and the amendments made by, this section
16 through program instruction or otherwise.

17 **SEC. 206. SPECIALIZED MEDICARE ADVANTAGE PLANS FOR**
18 **SPECIAL NEEDS INDIVIDUALS.**

19 (a) EXTENSION.—Section 1859(f)(1) of the Social
20 Security Act (42 U.S.C. 1395w–28(f)(1)) is amended—

21 (1) by striking “ENROLLMENT.—In the case”
22 and inserting “ENROLLMENT.—

23 “(A) IN GENERAL.—Subject to subpara-
24 graphs (B) and (C), in the case”;

1 (2) in subparagraph (A), as added by para-
2 graph (1), by striking “and for periods before Janu-
3 ary 1, 2016”; and

4 (3) by adding at the end the following new sub-
5 paragraphs:

6 “(B) APPLICATION TO DUAL SNPS.—Sub-
7 paragraph (A) shall only apply to a specialized
8 MA plan for special needs individuals described
9 in subsection (b)(6)(B)(ii) for periods before
10 January 1, 2021.

11 “(C) APPLICATION TO SEVERE OR DIS-
12 ABLING CHRONIC CONDITION SNPS.—Subpara-
13 graph (A) shall only apply to a specialized MA
14 plan for special needs individuals described in
15 subsection (b)(6)(B)(iii) for periods before Jan-
16 uary 1, 2018.”.

17 (b) INCREASED INTEGRATION OF DUAL SNPS.—

18 (1) IN GENERAL.—Section 1859(f) of the Social
19 Security Act (42 U.S.C. 1395w–28(f)) is amended—

20 (A) in paragraph (3), by adding at the end
21 the following new subparagraph:

22 “(F) The plan meets the requirements ap-
23 plicable under paragraph (8).”; and

24 (B) by adding at the end the following new
25 paragraph:

1 “(8) INCREASED INTEGRATION OF DUAL
2 SNPS.—

3 “(A) DESIGNATED CONTACT.—The Sec-
4 retary, acting through the Federal Coordinated
5 Health Care Office (Medicare-Medicaid Coordi-
6 nation Office) established under section 2602 of
7 the Patient Protection and Affordable Care Act
8 (in this paragraph referred to as the ‘MMCO’),
9 shall serve as a dedicated point of contact for
10 States to address misalignments that arise with
11 the integration of specialized MA plans for spe-
12 cial needs individuals described in subsection
13 (b)(6)(B)(ii) under this paragraph. Consistent
14 with such role, the MMCO shall—

15 “(i) establish a uniform process for
16 disseminating to State Medicaid agencies
17 information under this title impacting con-
18 tracts between such agencies and such
19 plans under this subsection; and

20 “(ii) establish basic resources for
21 States interested in exploring such plans
22 as a platform for integration.

23 “(B) UNIFIED GRIEVANCES AND APPEALS
24 PROCESS.—

1 “(i) IN GENERAL.—Not later than
2 April 1, 2015, the Secretary shall establish
3 procedures unifying the grievances and ap-
4 peals procedures under sections 1852(f),
5 1852(g), 1902(a)(3), and 1902(a)(5) for
6 items and services provided by specialized
7 MA plans for special needs individuals de-
8 scribed in subsection (b)(6)(B)(ii) under
9 this title and title XIX. The Secretary
10 shall solicit comment in developing such
11 procedures from States, plans, beneficiary
12 representatives, and other relevant stake-
13 holders.

14 “(ii) PROCEDURES.—The procedures
15 established under clause (i) shall—

16 “(I) adopt the most protective
17 provisions for the enrollee under cur-
18 rent law, including continuation of
19 benefits under title XIX pending ap-
20 peal if an appeal is filed in a timely
21 manner;

22 “(II) take into account dif-
23 ferences in State plans under title
24 XIX;

1 “(III) be easily navigable by an
2 enrollee; and

3 “(IV) include the elements de-
4 scribed in clause (iii).

5 “(iii) ELEMENTS DESCRIBED.—The
6 following elements are described in this
7 clause:

8 “(I) Single notification of all ap-
9 plicable grievances and appeal rights
10 under this title and title XIX.

11 “(II) Notices written in plain lan-
12 guage and available in a language and
13 format that is accessible to the en-
14 rollee.

15 “(III) Unified timeframes for in-
16 ternal and external grievances and ap-
17 peals processes, such as an individ-
18 ual’s filing of a grievance or appeal, a
19 plan’s acknowledgment and resolution
20 of a grievance or appeal, and notifica-
21 tion of decisions with respect to a
22 grievance or appeal.

23 “(IV) Guidelines to allow the
24 plan to process, track, and resolve
25 grievances and appeals, to ensure

1 beneficiaries are notified on a timely
2 basis of decisions that are made
3 throughout the grievance or appeals
4 process and are able to easily deter-
5 mine the status of a grievance or ap-
6 peal.

7 “(C) REQUIREMENT FOR UNIFIED GRIEV-
8 ANCES AND APPEALS.—

9 “(i) IN GENERAL.—For 2016 and
10 subsequent years, the contract of a special-
11 ized MA plan for special needs individuals
12 described in subsection (b)(6)(B)(ii) with a
13 State Medicaid agency under this sub-
14 section shall require the use of unified
15 grievances and appeals procedures as de-
16 scribed in subparagraph (B).

17 “(ii) CONSIDERATION OF APPLICA-
18 TION FOR OTHER SNPS.—The Secretary
19 shall consider applying the unified griev-
20 ances and appeals process described in
21 subparagraph (B) to specialized MA plans
22 for special needs individuals described in
23 subsection (b)(6)(B)(i) and subsection
24 (b)(6)(B)(iii) that have a substantial por-
25 tion of enrollees who are dually eligible for

1 benefits under this title and title XIX and
2 are at risk for full benefits under title
3 XIX.

4 “(D) REQUIREMENT FOR FULL INTEGRA-
5 TION FOR CERTAIN DUAL SNPS.—

6 “(i) REQUIREMENT.—Subject to the
7 succeeding provisions of this subparagraph,
8 for 2018 and subsequent years, a special-
9 ized MA plan for special needs individuals
10 described in subsection (b)(6)(B)(ii)
11 shall—

12 “(I) integrate all benefits under
13 this title and title XIX; and

14 “(II) meet the requirements of a
15 fully integrated plan described in sec-
16 tion 1853(a)(1)(B)(iv)(II) (other than
17 the requirement that the plan have
18 similar average levels of frailty, as de-
19 termined by the Secretary, as the
20 PACE program), including with re-
21 spect to long-term care services or be-
22 havioral health services to the extent
23 State law permits capitation of those
24 services under such plan.

1 “(ii) INITIAL SANCTIONS FOR FAIL-
2 URE TO MEET REQUIREMENT FOR 2018 OR
3 2019.—For each of 2018 and 2019, if the
4 Secretary determines that a plan has failed
5 to meet the requirement described in
6 clause (i), the Secretary shall impose one
7 of the following on the plan:

8 “(I) A reduction in payment to
9 the plan under this part in an amount
10 at least equal to the portion of the
11 monthly rebate computed under sec-
12 tion 1854(b)(1)(C)(i) for the plan and
13 year that would otherwise be kept by
14 the plan after application of the bene-
15 ficiary rebate rule under section
16 1854(b)(1)(C).

17 “(II) Closing enrollment in the
18 plan.

19 “(III) Sanctioning the plan in ac-
20 cordance with section 1857(g).

21 “(IV) Other reasonable action
22 (other than the sanction described in
23 clause (iii)) the Secretary determines
24 appropriate.

1 “(iii) SANCTIONS FOR FAILURE TO
2 MEET REQUIREMENT FOR 2020 AND SUBSE-
3 QUENT YEARS.—For 2020 and subsequent
4 years, if the Secretary determines that a
5 plan has failed to meet the requirement de-
6 scribed in clause (i), the plan shall be
7 deemed to no longer meet the definition of
8 a specialized MA plan for special needs in-
9 dividuals described in subsection
10 (b)(6)(B)(ii).

11 “(iv) LIMITATION.—This subpara-
12 graph shall not apply to a specialized MA
13 plan for special needs individuals described
14 in subsection (b)(6)(B)(ii) that only enrolls
15 individuals for whom the only medical as-
16 sistance to which the individuals are enti-
17 tled under the State plan is medicare cost
18 sharing described in section
19 1905(p)(3)(A)(ii).”

20 (2) CONFORMING AMENDMENT TO RESPON-
21 SIBILITIES OF FEDERAL COORDINATED HEALTH
22 CARE OFFICE (MMCO).—Section 2602(d) of the Pa-
23 tient Protection and Affordable Care Act (42 U.S.C.
24 1315b(d)) is amended by adding at the end the fol-
25 lowing new paragraph:

1 “(6) To act as a designated contact for States
2 under subsection (f)(8)(A) of section 1859 of the So-
3 cial Security Act (42 U.S.C. 1395w–28) with respect
4 to the integration of specialized MA plans for special
5 needs individuals described in subsection
6 (b)(6)(B)(ii) of such section.”.

7 (c) IMPROVEMENTS TO SEVERE OR DISABLING
8 CHRONIC CONDITION SNPS.—Section 1859(f)(5) of the
9 Social Security Act (42 U.S.C. 1395w–28(f)(5)) is amend-
10 ed—

11 (1) by striking “ALL SNPS.—The requirements”
12 and inserting “ALL SNPS.—

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (B), the requirements”;

15 (2) by redesignating subparagraphs (A) and
16 (B) as clauses (i) and (ii), respectively, and indent-
17 ing appropriately;

18 (3) in clause (ii), as redesignated by paragraph
19 (2), by redesignating clauses (i) through (iii) as sub-
20 clauses (I) through (III), respectively, and indenting
21 appropriately; and

22 (4) by adding at the end the following new sub-
23 paragraph:

24 “(B) IMPROVEMENTS TO CARE MANAGE-
25 MENT REQUIREMENTS FOR SEVERE OR DIS-

1 ABLING CHRONIC CONDITION SNPS.—For 2016
2 and subsequent years, in the case of a special-
3 ized MA plan for special needs individuals de-
4 scribed in subsection (b)(6)(B)(iii), the require-
5 ments described in this paragraph include the
6 following:

7 “(i) The interdisciplinary team under
8 subparagraph (A)(ii)(III) includes a team
9 of providers with demonstrated expertise,
10 including training in an applicable spe-
11 cialty, in treating individuals similar to the
12 targeted population of the plan.

13 “(ii) Requirements developed by the
14 Secretary to provide face-to-face encoun-
15 ters with individuals enrolled in the plan
16 not less frequently than on an annual
17 basis.

18 “(iii) As part of the model of care
19 under clause (i) of subparagraph (A), the
20 results of the initial assessment and an-
21 nual reassessment under clause (ii)(I) of
22 such subparagraph of each individual en-
23 rolled in the plan are addressed in the indi-
24 vidual’s individualized care plan under
25 clause (ii)(II) of such subparagraph.

1 “(iv) As part of the annual evaluation
2 and approval of such model of care, the
3 Secretary shall take into account whether
4 the plan fulfilled the previous year’s goals
5 (as required under the model of care).

6 “(v) The Secretary shall establish a
7 minimum benchmark for each element of
8 the model of care of a plan. The Secretary
9 shall only approve a plan’s model of care
10 under this paragraph if each element of
11 the model of care meets the minimum
12 benchmark applicable under the preceding
13 sentence.”.

14 (d) GAO STUDY ON QUALITY IMPROVEMENT.—

15 (1) STUDY.—The Comptroller General of the
16 United States shall conduct a study on how the Sec-
17 retary of Health and Human Services could change
18 the quality measurement system under the Medicare
19 Advantage program under part C of title XVIII of
20 the Social Security Act (42 U.S.C. 1395w–21 et
21 seq.) to allow an accurate comparison of the quality
22 of care provided by specialized MA plans for special
23 needs individuals (as defined in section 1859(b)(6)
24 of such Act (42 U.S.C. 1395w–28(b)(6)), both for
25 individual plans and such plans overall, compared to

1 the quality of care delivered by the original Medicare
 2 fee-for-service program under parts A and B of such
 3 title and other Medicare Advantage plans under such
 4 part C across similar populations.

5 (2) REPORT.—Not later than July 1, 2016, the
 6 Comptroller General shall submit to Congress a re-
 7 port containing the results of the study under para-
 8 graph (1), together with recommendations for such
 9 legislation and administrative action as the Comp-
 10 troller General determines appropriate.

11 (e) CHANGES TO QUALITY RATINGS AND MEASURE-
 12 MENT OF SNPs AND DETERMINATION OF FEASIBILITY
 13 OF QUALITY MEASUREMENT AT THE PLAN LEVEL.—Sec-
 14 tion 1853(o) of the Social Security Act (42 U.S.C. 1395w-
 15 23(o)) is amended by adding at the end the following new
 16 paragraphs:

17 “(6) CHANGES TO QUALITY RATINGS OF
 18 SNPS.—

19 “(A) EMPHASIS ON IMPROVEMENT ACROSS
 20 SNPS.—Subject to subparagraph (B), beginning
 21 in plan year 2016, in the case of a specialized
 22 MA plan for special needs individuals, the Sec-
 23 retary shall increase the emphasis on the plan’s
 24 improvement or decline in performance when

1 determining the star rating of the plan under
2 this subsection for the year as follows:

3 “(i)(I) For plan year 2016, at least
4 10 percent, but not more than 12 percent,
5 of the total star rating of the plan shall be
6 based on improvement or decline in per-
7 formance.

8 “(II) For plan year 2017 and subse-
9 quent plan years, at least 12 percent, but
10 not more than 15 percent, of the total star
11 rating of the plan shall be based on im-
12 provement or decline in performance.

13 “(ii) Improvement or decline in per-
14 formance under this subparagraph shall be
15 measured based on net change in the indi-
16 vidual star rating measures of the plan,
17 with appropriate weight given to specific
18 individual star ratings measures, such as
19 readmission rates, as determined by the
20 Secretary.

21 “(iii) The Secretary shall make an ap-
22 propriate adjustment to the improvement
23 rating of a plan under this subparagraph
24 if the plan has achieved a 4.5-star rating
25 or the highest rating possible overall or for

1 an individual measure in order to ensure
2 that the plan is not punished in cases
3 where it is not possible to improve.

4 “(B) NO APPLICATION TO CERTAIN
5 PLANS.—Subparagraph (A) shall not apply,
6 with respect to a year, to a specialized MA plan
7 for special needs individuals that has a rating
8 that is less than two-and-one-half stars.

9 “(C) QUALITY MEASUREMENT AT THE
10 PLAN LEVEL.—

11 “(i) IN GENERAL.—The Secretary
12 may require reporting for and apply under
13 this subsection quality measures at the
14 plan level for specialized MA plan for spe-
15 cial needs individuals instead of at the con-
16 tract level.

17 “(ii) CONSIDERATION.—The Secretary
18 shall take into consideration the minimum
19 number of enrollees in a specialized MA
20 plan for special needs individuals in order
21 to determine if a statistically significant or
22 valid measurement of quality at the plan
23 level is possible under clause (i).

1 “(iii) APPLICATION.—If the Secretary
2 applies quality measurement at the plan
3 level under this subparagraph—

4 “(I) such quality measurement
5 shall include Medicare Health Out-
6 comes Survey (HOS), Healthcare Ef-
7 fectiveness Data and Information Set
8 (HEDIS), and Consumer Assessment
9 of Healthcare Providers and Systems
10 (CAHPS) measures; and

11 “(II) payment and other adminis-
12 trative actions linked to quality meas-
13 urement (including the 5-star rating
14 system under this subsection) shall be
15 applied at the plan level in accordance
16 with this subparagraph.

17 “(7) DETERMINATION OF FEASIBILITY OF
18 QUALITY MEASUREMENT AT THE PLAN LEVEL.—

19 “(A) DETERMINATION OF FEASIBILITY.—
20 The Secretary shall determine the feasibility of
21 requiring reporting for and applying under this
22 subsection quality measures at the plan level for
23 all MA plans under this part.

24 “(B) CONSIDERATION OF CHANGE.—After
25 making a determination under subparagraph

1 (A), the Secretary shall consider requiring such
 2 reporting and applying such quality measures
 3 at the plan level as described in such subpara-
 4 graph.”.

5 **SEC. 207. REASONABLE COST REIMBURSEMENT CON-**
 6 **TRACTS.**

7 (a) ONE-YEAR TRANSITION AND NOTICE REGARDING
 8 TRANSITION.—Section 1876(h)(5)(C) of the Social Secu-
 9 rity Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

10 (1) in clause (ii), in the matter preceding sub-
 11 clause (I), by striking “For any” and inserting
 12 “Subject to clause (iv), for any”; and

13 (2) by adding at the end the following new
 14 clauses:

15 “(iv) In the case of an eligible organization that is
 16 offering a reasonable cost reimbursement contract that
 17 may no longer be extended or renewed because of the ap-
 18 plication of clause (ii), the following shall apply:

19 “(I) Notwithstanding such clause, such contract
 20 may be extended or renewed for the two years subse-
 21 quent to the previous year described in clause (ii).
 22 The second of the two years described in the pre-
 23 ceding sentence with respect to a contract is referred
 24 to in this subsection as the ‘last reasonable cost re-
 25 imbursement contract year for the contract’.

1 “(II) The organization may not enroll any new
2 enrollees under such contract during the last reason-
3 able cost reimbursement contract year for the con-
4 tract.

5 “(III) Not later than a date determined appro-
6 priate by the Secretary prior to the beginning of the
7 last reasonable cost reimbursement contract year for
8 the contract, the organization shall provide notice to
9 the Secretary as to whether or not the organization
10 will apply to have the contract converted over and
11 offered as a Medicare Advantage plan under part C
12 for the year following the last reasonable cost reim-
13 bursement contract year for the contract.

14 “(IV) If the organization provides the notice de-
15 scribed in subclause (III) that the contract will be
16 converted, the organization shall, not later than a
17 date determined appropriate by the Secretary, pro-
18 vide the Secretary with such information as the Sec-
19 retary determines appropriate in order to carry out
20 sections 1851(c)(4) and 1854(a)(5), including sub-
21 paragraph (C) of such section.

22 “(v) If an eligible organization that is offering a rea-
23 sonable cost reimbursement contract that is extended or
24 renewed pursuant to clause (iv) provides the notice de-

1 scribed in clause (iv)(III) that the contract will be con-
 2 verted, the following provisions shall apply:

3 “(I) The deemed enrollment under section
 4 1851(e)(4).

5 “(II) The special rule for quality increases
 6 under 1853(o)(3)(A)(iv).”.

7 (b) DEEMED ENROLLMENT FROM REASONABLE
 8 COST REIMBURSEMENT CONTRACTS CONVERTED TO
 9 MEDICARE ADVANTAGE PLANS.—

10 (1) IN GENERAL.—Section 1851(c) of the So-
 11 cial Security Act (42 U.S.C. 1395w-21(c)) is
 12 amended—

13 (A) in paragraph (1), by striking “Such
 14 elections” and inserting “Subject to paragraph
 15 (4), such elections”; and

16 (B) by adding at the end the following:

17 “(4) DEEMED ENROLLMENT RELATING TO CON-
 18 VERTED REASONABLE COST REIMBURSEMENT CON-
 19 TRACTS.—

20 “(A) IN GENERAL.—On the first day of
 21 the annual, coordinated election period under
 22 subsection (e)(3) for plan years beginning on or
 23 after January 1, 2017, an MA eligible indi-
 24 vidual described in clause (i) or (ii) of subpara-
 25 graph (B) is deemed to have elected to receive

1 benefits under this title through an applicable
2 MA plan (and shall be enrolled in such plan)
3 beginning with such plan year, if—

4 “(i) the individual is enrolled in a rea-
5 sonable cost reimbursement contract under
6 section 1876(h) in the previous plan year;

7 “(ii) such reasonable cost reimburse-
8 ment contract was extended or renewed for
9 the last reasonable cost reimbursement
10 contract year of the contract pursuant to
11 section 1876(h)(5)(C)(iv);

12 “(iii) the eligible organization that is
13 offering such reasonable cost reimburse-
14 ment contract provided the notice de-
15 scribed in subclause (III) of such section
16 that the contract was to be converted;

17 “(iv) the applicable MA plan—

18 “(I) is the plan that was con-
19 verted from the reasonable cost reim-
20 bursement contract described in
21 clause (iii);

22 “(II) is offered by the same enti-
23 ty (or an organization affiliated with
24 such entity that has a common owner-

1 ship interest of control) that entered
2 into such contract; and

3 “(III) is offered in the service
4 area where the individual resides;

5 “(v) the applicable MA plan provides
6 benefits, premiums, and access to in-net-
7 work and out-of-network providers that are
8 comparable to the benefits, premiums, and
9 access to in-network and out-of-network
10 providers under such reasonable cost reim-
11 bursement contract for the previous plan
12 year; and

13 “(vi) the applicable MA plan—

14 “(I) allows enrollees transitioning
15 from the converted reasonable cost
16 contract to such plan to maintain cur-
17 rent providers and course of treat-
18 ment at the time of enrollment for at
19 least 90 days after enrollment; and

20 “(II) during such period, pays
21 non-contracting providers for items
22 and services furnished to the enrollee
23 an amount that is not less than the
24 amount of payment applicable for
25 those items and services under the

1 original medicare fee-for-service pro-
2 gram under parts A and B.

3 “(B) MA ELIGIBLE INDIVIDUALS DE-
4 SCRIBED.—

5 “(i) WITHOUT PRESCRIPTION DRUG
6 COVERAGE.—An MA eligible individual de-
7 scribed in this clause, with respect to a
8 plan year, is an MA eligible individual who
9 is enrolled in a reasonable cost reimburse-
10 ment contract under section 1876(h) in the
11 previous plan year and who does not, for
12 such previous plan year, receive any pre-
13 scription drug coverage under part D, in-
14 cluding coverage under section 1860D–22.

15 “(ii) WITH PRESCRIPTION DRUG COV-
16 ERAGE.—An MA eligible individual de-
17 scribed in this clause, with respect to a
18 plan year, is an MA eligible individual who
19 is enrolled in a reasonable cost reimburse-
20 ment contract under section 1876(h) in the
21 previous plan year and who, for such pre-
22 vious plan year, receives prescription drug
23 coverage under part D—

24 “(I) through such contract; or

1 “(II) through a prescription drug
2 plan, if the sponsor of such plan is the
3 same entity (or an organization affili-
4 ated with such entity) that entered
5 into such contract.

6 “(C) APPLICABLE MA PLAN DEFINED.—In
7 this paragraph, the term ‘applicable MA plan’
8 means, in the case of an individual described
9 in—

10 “(i) subparagraph (B)(i), an MA plan
11 that is not an MA–PD plan; and

12 “(ii) subparagraph (B)(ii), an MA–
13 PD plan.

14 “(D) IDENTIFICATION AND NOTIFICATION
15 OF DEEMED INDIVIDUALS.—Not later than 30
16 days before the first day of the annual, coordi-
17 nated election period under subsection (e)(3)
18 for plan years beginning on or after January 1,
19 2017, the Secretary shall identify and notify the
20 individuals who will be subject to deemed elec-
21 tions under subparagraph (A) on the first day
22 of such period.”.

23 (2) BENEFICIARY OPTION TO DISCONTINUE OR
24 CHANGE MA PLAN OR MA–PD PLAN AFTER DEEMED
25 ENROLLMENT.—

1 (A) IN GENERAL.—Section 1851(e)(2) of
2 the Social Security Act (42 U.S.C. 1395w–
3 21(e)(4)) is amended by adding at the end the
4 following:

5 “(F) SPECIAL PERIOD FOR CERTAIN
6 DEEMED ELECTIONS.—

7 “(i) IN GENERAL.—At any time dur-
8 ing the period beginning after the last day
9 of the annual, coordinated election period
10 under paragraph (3) in which an individual
11 is deemed to have elected to enroll in an
12 MA plan or MA–PD plan under subsection
13 (c)(4) and ending on the last day of Feb-
14 ruary of the first plan year for which the
15 individual is enrolled in such plan, such in-
16 dividual may change the election under
17 subsection (a)(1) (including changing the
18 MA plan or MA–PD plan in which the in-
19 dividual is enrolled).

20 “(ii) LIMITATION OF ONE CHANGE.—
21 An individual may exercise the right under
22 clause (i) only once during the applicable
23 period described in such clause. The limita-
24 tion under this clause shall not apply to
25 changes in elections effected during an an-

1 nual, coordinated election period under
2 paragraph (3) or during a special enroll-
3 ment period under paragraph (4).”.

4 (B) CONFORMING AMENDMENTS.—

5 (i) PLAN REQUIREMENT FOR OPEN
6 ENROLLMENT.—Section 1851(e)(6)(A) of
7 the Social Security Act (42 U.S.C. 1395w-
8 21(e)(6)(A)) is amended by striking “para-
9 graph (1),” and inserting “paragraph (1),
10 during the period described in paragraph
11 (2)(F),”.

12 (ii) PART D.—Section 1860D-
13 1(b)(1)(B) of such Act (42 U.S.C. 1395w-
14 101(b)(1)(B)) is amended—

15 (I) in clause (ii), by adding “and
16 paragraph (4)” after “paragraph
17 (3)(A)”; and

18 (II) in clause (iii) by striking
19 “and (E)” and inserting “(E), and
20 (F)”.

21 (3) TREATMENT OF ESRD FOR DEEMED EN-
22 ROLLMENT.—Section 1851(a)(3)(B) of the Social
23 Security Act (42 U.S.C. 1395w-21(a)(3)(B)) is
24 amended by adding at the end the following flush
25 sentence:

1 “An individual who develops end-stage renal
2 disease while enrolled in a reasonable cost reim-
3 bursement contract under section 1876(h) shall
4 be treated as an MA eligible individual for pur-
5 poses of applying the deemed enrollment under
6 subsection (c)(4).”.

7 (c) INFORMATION REQUIREMENTS.—Section
8 1851(d)(2)(B) of the Social Security Act (42 U.S.C.
9 1395w–21(d)(2)(B)) is amended—

10 (1) by striking the subparagraph heading and
11 inserting the following: “(i) NOTIFICATION TO
12 NEWLY ELIGIBLE MEDICARE ADVANTAGE ELIGIBLE
13 INDIVIDUALS.—”; and

14 (2) by adding at the end the following:

15 “(ii) NOTIFICATION RELATED TO CERTAIN
16 DEEMED ELECTIONS.—The Secretary shall re-
17 quire the converting cost plan to mail, not later
18 than 15 days prior to the first day of the an-
19 nual, coordinated election period under sub-
20 section (e)(3) of a year, to any individual iden-
21 tified by the Secretary under subsection
22 (c)(4)(D) for such year—

23 “(I) a notification that such individual
24 will, on such day, be deemed to have made
25 an election to receive benefits under this

1 title through an MA plan or MA–PD plan
2 (and shall be enrolled in such plan) for the
3 next plan year under subsection (e)(4)(A),
4 but that the individual may make a dif-
5 ferent election during the annual, coordi-
6 nated election period for such year;

7 “(II) the information described in
8 subparagraph (A);

9 “(III) a description of the differences
10 between such MA plan or MA–PD plan
11 and the reasonable cost reimbursement
12 contract in which the individual was most
13 recently enrolled with respect to benefits
14 covered under such plans, including cost-
15 sharing, premiums, drug coverage, and
16 provider networks;

17 “(IV) information about the special
18 period for elections under subsection
19 (e)(2)(F); and

20 “(V) other information the Secretary
21 may specify”.

22 (d) TREATMENT OF TRANSITION PLAN FOR QUALITY
23 RATING FOR PAYMENT PURPOSES.—Section 1853(o)(4)
24 of the Social Security Act (42 U.S.C. 1395w–23(o)(4)) is

1 amended by adding at the end the following new subpara-
2 graph:

3 “(C) SPECIAL RULE FOR FIRST 3 PLAN
4 YEARS FOR PLANS THAT WERE CONVERTED
5 FROM A REASONABLE COST REIMBURSEMENT
6 CONTRACT.—For purposes of applying para-
7 graph (1) and section 1854(b)(1)(C) for the
8 first 3 plan years under this part in the case of
9 an MA plan to which deemed enrollment applies
10 under section 1851(c)(4)—

11 “(i) such plan shall not be treated as
12 a new plan (as defined in paragraph
13 (3)(A)(iii)(II)); and

14 “(ii) in determining the star rating of
15 the plan under subparagraph (A), to the
16 extent that Medicare Advantage data for
17 such plan is not available for a measure
18 used to determine such star rating, the
19 Secretary shall use data from the period in
20 which such plan was a reasonable cost re-
21 imbursement contract.”.

22 **SEC. 208. QUALITY MEASURE ENDORSEMENT AND SELEC-**
23 **TION.**

24 (a) CONTRACT WITH AN ENTITY REGARDING INPUT
25 ON THE SELECTION OF MEASURES.—

1 (1) IN GENERAL.—Title XVIII of the Social Se-
2 curity Act (42 U.S.C. 1395 et seq.) is amended—

3 (A) by redesignating section 1890A as sec-
4 tion 1890B; and

5 (B) by inserting after section 1890 the fol-
6 lowing new section:

7 “CONTRACT WITH AN ENTITY REGARDING INPUT ON THE
8 SELECTION OF MEASURES

9 “SEC. 1890A (a) CONTRACT.—

10 “(1) IN GENERAL.—For purposes of activities
11 conducted under this Act, the Secretary shall iden-
12 tify and have in effect a contract with an entity that
13 meets the requirements described in subsection (c).
14 Such contract shall provide that the entity will per-
15 form the duties described in subsection (b).

16 “(2) TIMING FOR FIRST CONTRACT.—The first
17 contract under paragraph (1) shall begin on, or as
18 soon as practicable after, October 1, 2014.

19 “(3) PERIOD OF CONTRACT.—A contract under
20 paragraph (1) shall be for a period of 3 years (ex-
21 cept as may be renewed after a subsequent bidding
22 process).

23 “(4) COMPETITIVE PROCEDURES.—Competitive
24 procedures (as defined in section 4(5) of the Office
25 of Federal Procurement Policy Act (41 U.S.C.

1 403(5))) shall be used to enter into a contract under
2 paragraph (1).

3 “(b) DUTIES.—The duties described in this sub-
4 section are the following:

5 “(c) REQUIREMENTS DESCRIBED.—The require-
6 ments described in this subsection are the following:

7 “(1) PRIVATE NONPROFIT, BOARD MEMBER-
8 SHIP, MEMBERSHIP FEES, AND NOT A MEASURE DE-
9 VELOPER.—The requirements described in para-
10 graphs (1), (2), (7), and (8) of section 1890(c).

11 “(2) EXPERIENCE.—The entity has at least 4
12 years of experience working with quality and effi-
13 ciency measures.”.

14 (2) DUTIES OF ENTITY.—

15 (A) TRANSFER OF PRIORITY SETTING
16 PROCESS.—Paragraph (1) of section 1890(b) of
17 the Social Security Act (42 U.S.C. 1395aaa(b))
18 is redesignated as paragraph (1) of section
19 1890A(b) of such Act, as added by paragraph
20 (1).

21 (B) TRANSFER OF MULTI-STAKEHOLDER
22 PROCESS.—Paragraphs (7) and (8) of such sec-
23 tion 1890(b) are redesignated as paragraphs
24 (2) and (3), respectively, of section 1890A(b) of

1 such Act, as added by paragraph (1) and
2 amended by subparagraph (A).

3 (C) ADDITIONAL DUTIES.—Section
4 1890A(b) of such Act, as added by paragraph
5 (1) and amended by subparagraphs (A) and
6 (B), is amended by adding at the end the fol-
7 lowing new paragraphs:

8 “(4) FACILITATION TO BETTER COORDINATE
9 AND ALIGN PUBLIC AND PRIVATE SECTOR USE OF
10 QUALITY MEASURES.—

11 “(A) IN GENERAL.—The entity shall facili-
12 tate increased coordination and alignment be-
13 tween the public and private sector with respect
14 to quality and efficiency measures.

15 “(B) REPORTS.—The entity shall prepare
16 and make available to the public annual reports
17 on its findings under this paragraph. Such pub-
18 lic availability shall include posting each report
19 on the Internet website of the entity.

20 “(5) GAP ANALYSIS.—The entity shall conduct
21 an ongoing analysis of—

22 “(A) gaps in endorsed quality and effi-
23 ciency measures, which shall include measures
24 that are within priority areas identified by the
25 Secretary under the national strategy estab-

1 lished under section 399HH of the Public
2 Health Service Act; and

3 “(B) areas where quality measures are un-
4 available or inadequate to identify or address
5 such gaps.

6 “(6) ANNUAL REPORT TO CONGRESS AND THE
7 SECRETARY; SECRETARIAL PUBLICATION AND COM-
8 MENT.—

9 “(A) ANNUAL REPORT.—By not later than
10 June 1 of each year, the entity shall submit to
11 Congress and the Secretary a report con-
12 taining—

13 “(i) a description of—

14 “(I) the recommendations made
15 under paragraph (1);

16 “(II) the matters described in
17 clauses (i) and (ii) of paragraph
18 (2)(A);

19 “(III) the results of the analysis
20 under paragraph (5); and

21 “(IV) the performance by the en-
22 tity of the duties required under the
23 contract entered into with the Sec-
24 retary under subsection (a); and

1 “(ii) any other items determined ap-
2 propriate by the Secretary.

3 “(B) SECRETARIAL REVIEW AND PUBLICA-
4 TION OF ANNUAL REPORT.—Not later than 6
5 months after receiving a report under subpara-
6 graph (A), the Secretary shall—

7 “(i) review such report; and

8 “(ii) publish such report in the Fed-
9 eral Register, together with any comments
10 of the Secretary on such report.”.

11 (D) ADDITIONAL AMENDMENTS.—Section
12 1890A(b) of such Act, as so added and amend-
13 ed, is amended—

14 (i) in paragraph (2)—

15 (I) in subparagraph (A)(i)—

16 (aa) in subclause (I), by in-
17 serting “with a contract under
18 section 1890” after “entity”; and

19 (bb) in subclause (II), by
20 striking “such entity” and insert-
21 ing “the entity with a contract
22 under section 1890”;

23 (II) in the heading of subpara-
24 graph (B) by inserting “AND EFFI-
25 CIENCY” after “QUALITY”;

1 (III) in subparagraph (B)(i)(III),
2 by striking “this Act” and inserting
3 “this title”; and

4 (IV) by adding at the end the fol-
5 lowing new subparagraphs:

6 “(E) INPUT.—In providing the input de-
7 scribed in subparagraph (A), the multi-stake-
8 holder groups—

9 “(i) shall include a detailed descrip-
10 tion of the rationale for each recommenda-
11 tion made by the multi-stakeholder group,
12 including in areas relating to—

13 “(I) the expected impact that im-
14 plementing the measure will have on
15 individuals;

16 “(II) the burden on providers of
17 services and suppliers;

18 “(III) the expected influence over
19 the behavior of providers of services
20 and suppliers;

21 “(IV) the applicability of a meas-
22 ure for more than one setting or pro-
23 gram; and

24 “(V) other areas determined in
25 consultation with the Secretary; and

1 “(ii) may consider whether it is appro-
2 priate to provide separate recommenda-
3 tions with respect to measures for internal
4 use, public reporting, and payment provi-
5 sions.

6 “(F) EQUAL REPRESENTATION.—In con-
7 vening multi-stakeholder groups pursuant to
8 this paragraph, the entity shall, to the extent
9 feasible, make every effort to ensure such
10 groups are balanced across stakeholders.”; and

11 (ii) in paragraph (3), by striking “Not
12 later” and all that follows through the pe-
13 riod at the end and inserting the following:
14 “Not later than the applicable dates de-
15 scribed in section 1890B(a)(3) of each
16 year (or, as applicable, the timeframe de-
17 scribed in section 1890B(a)(4)), the entity
18 shall transmit to the Secretary the input of
19 the multi-stakeholder groups under para-
20 graph (2).”.

21 (b) REVISIONS TO CONTRACT WITH CONSENSUS-
22 BASED ENTITY.—

23 (1) CONTRACT.—Section 1890(a) of the Social
24 Security Act (42 U.S.C. 1395aaa(a)) is amended—

1 (A) in paragraph (1), by striking “, such
2 as the National Quality Forum,”; and

3 (B) in paragraph (3), by striking “4
4 years” and inserting “3 years”.

5 (2) DUTIES.—Section 1890(b) of the Social Se-
6 curity Act (42 U.S.C. 1395aaa(b)), as amended by
7 subsection (a)(2), is amended—

8 (A) by redesignating paragraphs (2) and
9 (3) as paragraphs (1) and (2), respectively;

10 (B) in paragraph (2), as redesignated by
11 subparagraph (A), by striking “paragraph (2)”
12 and inserting “paragraph (1)”;

13 (C) by striking paragraphs (5) and (6);
14 and

15 (D) by adding at the end the following new
16 paragraphs:

17 “(3) FACILITATION TO BETTER COORDINATE
18 AND ALIGN PUBLIC AND PRIVATE SECTOR USE OF
19 QUALITY MEASURES.—

20 “(A) IN GENERAL.—The entity shall facili-
21 tate increased coordination and alignment be-
22 tween the public and private sector with respect
23 to quality and efficiency measures.

24 “(B) REPORTS.—The entity shall prepare
25 and make available to the public annual reports

1 on its findings under this paragraph. Such pub-
2 lic availability shall include posting each report
3 on the Internet website of the entity.

4 “(4) ANNUAL REPORT TO CONGRESS AND THE
5 SECRETARY; SECRETARIAL PUBLICATION AND COM-
6 MENT.—

7 “(A) ANNUAL REPORT.—By not later than
8 March 1 of each year, the entity shall submit
9 to Congress and the Secretary a report con-
10 taining—

11 “(i) a description of—

12 “(I) the coordination of quality
13 initiatives under this title and titles
14 XIX and XXI with quality initiatives
15 implemented by other payers;

16 “(II) areas in which evidence is
17 insufficient to support endorsement of
18 quality measures in priority areas
19 identified by the Secretary under the
20 national strategy established under
21 section 399HH of the Public Health
22 Service Act and where targeted re-
23 search may address such gaps; and

24 “(III) the performance by the en-
25 tity of the duties required under the

1 contract entered into with the Sec-
2 retary under subsection (a); and

3 “(ii) any other items determined ap-
4 propriate by the Secretary.

5 “(B) SECRETARIAL REVIEW AND PUBLICA-
6 TION OF ANNUAL REPORT.—Not later than 6
7 months after receiving a report under subpara-
8 graph (A), the Secretary shall—

9 “(i) review such report; and

10 “(ii) publish such report in the Fed-
11 eral Register, together with any comments
12 of the Secretary on such report.”.

13 (3) REQUIREMENTS.—Section 1890(e) of the
14 Social Security Act (42 U.S.C. 1395aaa(c)) is
15 amended by adding at the end the following new
16 paragraph:

17 “(8) NOT A MEASURE DEVELOPER.—The entity
18 is not a measure developer.”.

19 (c) REVISIONS TO DUTIES OF THE SECRETARY RE-
20 GARDING USE OF MEASURES.—

21 (1) IN GENERAL.—Section 1890B(a) of the So-
22 cial Security Act (42 U.S.C. 1395aaa–1(a)), as re-
23 designated by subsection (a)(1)(A), is amended—

1 (A) by striking “section 1890(b)(7)(B)”
2 each place it appears and inserting “section
3 1890A(b)(2)(B)”;

4 (B) in paragraph (1)—

5 (i) by striking “section 1890(b)(7)”
6 and inserting “section 1890A(b)(2)”; and

7 (ii) by striking “section 1890” and in-
8 serting “section 1890A”;

9 (C) by striking paragraphs (2) and (3) and
10 inserting the following:

11 “(2) PUBLIC AVAILABILITY OF MEASURES CON-
12 sidered for selection.—Subject to paragraph
13 (4), not later than October 1 or December 31 of
14 each year (or as soon as practicable after such dates
15 for the first year of the contract), the Secretary
16 shall make available to the public a list of quality
17 and efficiency measures described in section
18 1890A(b)(2)(B) that the Secretary is considering
19 under this title. The Secretary shall provide for an
20 appropriate balance of the number of measures to be
21 made available by each such date in a year.

22 “(3) TRANSMISSION OF MULTI-STAKEHOLDER
23 INPUT.—

24 “(A) IN GENERAL.—Subject to paragraph
25 (4), not later than the applicable date described

1 in subparagraph (B) of each year, the entity
2 with a contract under section 1890A shall, pur-
3 suant to subsection (b)(3) of such section,
4 transmit to the Secretary the input of multi-
5 stakeholder groups described in paragraph (1).

6 “(B) APPLICABLE DATE DESCRIBED.—The
7 applicable date described in this subparagraph
8 for a year is—

9 “(i) February 1 (or as soon as prac-
10 ticable after such date for the first year of
11 the contract) with respect to quality and
12 efficiency measures made available under
13 paragraph (2) by October 1 of the pre-
14 ceding year; and

15 “(ii) April 1 (or as soon as practicable
16 after such dates for the first year of the
17 contract) with respect to quality and effi-
18 ciency measures made available under
19 paragraph (2) by December 31 of the pre-
20 ceding year.”;

21 (D) by redesignating—

22 (i) paragraph (6) as paragraph (8);

23 and

24 (ii) paragraphs (4) and (5) as para-
25 graphs (5) and (6), respectively;

1 (E) by inserting after paragraph (3) the
2 following new paragraph:

3 “(4) LIMITED PROCESS FOR ADDITIONAL
4 MULTI-STAKEHOLDER INPUT.—In addition to the
5 Secretary making measures publically available pur-
6 suant to the dates described in paragraph (2) and
7 multi-stakeholder groups transmitting the input pur-
8 suant to the applicable dates described in paragraph
9 (3)—

10 “(A) the Secretary may, at times that do
11 not meet the time requirements described in
12 paragraph (2), make available to the public a
13 limited number of quality and efficiency meas-
14 ures described in section 1890A(b)(2) that the
15 Secretary is considering under this title; and

16 “(B) if the Secretary uses the authority
17 under subparagraph (A), the entity with a con-
18 tract under section 1890A shall, pursuant to
19 section 1890A(b)(3), transmit to the Secretary
20 on a timely basis the input from a multi-stake-
21 holder group described in paragraph (1) with
22 respect to such measures.”;

23 (F) in paragraph (6), as redesignated by
24 subparagraph (D)(ii), by inserting “or that has
25 not been recommended by the multi-stakeholder

1 group under section 1890A(b)(2)” before the
2 period at the end; and

3 (G) by inserting after paragraph (6) the
4 following new paragraph:

5 “(7) CONCORDANCE RATES.—For each year
6 (beginning with 2015), the Secretary shall include a
7 list of concordance rates with respect to the input
8 provided under section 1890A(b)(2)(A) for those
9 new measures adopted for each type of provider of
10 services and supplier in the annual final rule appli-
11 cable to such type of provider or supplier.”.

12 (2) REVIEW.—Section 1890B(c) of the Social
13 Security Act (42 U.S.C. 1395aaa–1(c)), as redesign-
14 nated by subsection (a)(1)(A), is amended—

15 (A) in paragraph (1)(A), by striking “sec-
16 tion 1890(b)(7)(B)” and inserting “section
17 1890A(b)(2)(B)”; and

18 (B) in paragraph (2)—

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

21 (ii) in subparagraph (B), by striking
22 the period at the end and inserting “;
23 and”; and

24 (iii) by adding at the end the fol-
25 lowing new subparagraph:

1 “(C) take into consideration the benefits of
2 the alignment of measures between the public
3 and private sector.”.

4 (d) FUNDING FOR QUALITY MEASURE ENDORSE-
5 MENT, INPUT, AND SELECTION.—

6 (1) FISCAL YEAR 2014.—In addition to amounts
7 transferred under section 3014(c) of the Patient
8 Protection and Affordable Care Act (Public Law
9 111–148), for purposes of carrying out section 1890
10 and section 1890A (other than subsections (e) and
11 (f)), the Secretary shall provide for the transfer,
12 from the Federal Hospital Insurance Trust Fund
13 under section 1817 and the Federal Supplementary
14 Medical Insurance Trust Fund under section 1841,
15 in such proportion as the Secretary determines ap-
16 propriate, to the Centers for Medicare & Medicaid
17 Services Program Management Account of
18 \$7,000,000 for fiscal year 2014. Amounts trans-
19 ferred under the preceding sentence shall remain
20 available until expended.

21 (2) FISCAL YEARS 2015 THROUGH 2017.—Sec-
22 tion 1890B of the Social Security Act (42 U.S.C.
23 1395aaa–1), as redesignated by subsection
24 (a)(1)(A), is amended by adding at the end the fol-
25 lowing new subsection:

1 “(g) FUNDING.—

2 “(1) IN GENERAL.—For purposes of carrying
3 out this section (other than subsections (e) and (f))
4 and sections 1890 and 1890A, the Secretary shall
5 provide for the transfer, from the Federal Hospital
6 Insurance Trust Fund under section 1817 and the
7 Federal Supplementary Medical Insurance Trust
8 Fund under section 1841, in such proportion as the
9 Secretary determines appropriate, to the Centers for
10 Medicare & Medicaid Services Program Management
11 Account of \$25,000,000 for each of fiscal years
12 2015 through 2017.

13 “(2) AVAILABILITY.—Amounts transferred
14 under paragraph (1) shall remain available until ex-
15 pended.”.

16 (3) CONFORMING AMENDMENT.—Subsection (d)
17 of section 1890 of the Social Security Act (42
18 U.S.C. 1395aaa) is repealed.

19 (e) CONFORMING AMENDMENTS.—(1) Section
20 1848(m)(3)(E)(iii) of the Social Security Act (42 U.S.C.
21 1395w-4(m)(3)(E)(iii)) is amended by striking “section
22 1890(b)(7) and 1890A(a)” and inserting “section
23 1890A(b)(2) and 1890B(a)”.

24 (2) Section 1866D(b)(2)(C) of the Social Security
25 Act (42 U.S.C. 1395cc-4(b)(2)(C)) is amended by striking

1 “section 1890 and 1890A” and inserting “sections 1890,
2 1890A, and 1890B”.

3 (3) Section 1899A(n)(2)(A) of the Social Security
4 Act (42 U.S.C. 1395cc–4(n)(2)(A)) is amended by strik-
5 ing “section 1890(b)(7)(B)” and inserting “section
6 1890A(b)(2)(B)”.

7 (f) EFFECTIVE DATE.—

8 (1) IN GENERAL.—The amendments made by
9 this section shall take effect on October 1, 2014,
10 and shall apply with respect to contract periods
11 under sections 1890 and 1890A of the Social Secu-
12 rity Act that begin on or after such date.

13 (2) NEW CONTRACTS.—The Secretary of
14 Health and Human Services shall enter into a new
15 contract under both sections 1890 and 1890A of the
16 Social Security Act, as amended by this Act, for a
17 contract period beginning on, or as soon as prac-
18 ticable after, October 1, 2014.

19 **SEC. 209. PERMANENT EXTENSION OF FUNDING OUTREACH**
20 **AND ASSISTANCE FOR LOW-INCOME PRO-**
21 **GRAMS.**

22 (a) ADDITIONAL FUNDING FOR STATE HEALTH IN-
23 SURANCE PROGRAMS.—Subsection (a)(1)(B)(iv) of section
24 119 of the Medicare Improvements for Patients and Pro-
25 viders Act of 2008 (42 U.S.C. 1395b–3 note), as amended

1 by section 3306 of the Patient Protection and Affordable
2 Care Act (Public Law 111–148), section 610 of the Amer-
3 ican Taxpayer Relief Act of 2012 (Public Law 112–240),
4 and section 1110 of the Pathway for SGR Reform Act
5 of 2013 (Public Law 113–67), is amended to read as fol-
6 lows:

7 “(iv) for fiscal year 2014 and for each
8 subsequent fiscal year, \$7,500,000.”.

9 (b) ADDITIONAL FUNDING FOR AREA AGENCIES ON
10 AGING.—Subsection (b)(1)(B)(iv) of such section 119, as
11 so amended, is amended to read as follows:

12 “(iv) for fiscal year 2014 and for each
13 subsequent fiscal year, \$7,500,000.”.

14 (c) ADDITIONAL FUNDING FOR AGING AND DIS-
15 ABILITY RESOURCE CENTERS.—Subsection (c)(1)(B)(iv)
16 of such section 119, as so amended, is amended to read
17 as follows:

18 “(iv) for fiscal year 2014 and for each
19 subsequent fiscal year, \$5,000,000.”.

20 (d) ADDITIONAL FUNDING FOR CONTRACT WITH
21 THE NATIONAL CENTER FOR BENEFITS AND OUTREACH
22 ENROLLMENT.—Subsection (d)(2)(iv) of such section 119,
23 as so amended, is amended to read as follows:

24 “(iv) for fiscal year 2014 and for each
25 subsequent fiscal year, \$5,000,000.”.

1 **Subtitle B—Medicaid and Other**
2 **Extensions**

3 **SEC. 211. QUALIFYING INDIVIDUAL PROGRAM.**

4 (a) **EXTENSION.**—Section 1902(a)(10)(E)(iv) of the
5 Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is
6 amended by striking “March 2104” and inserting “De-
7 cember 2018”.

8 (b) **ELIMINATING LIMITATIONS ON ELIGIBILITY.**—
9 Section 1933 of the Social Security Act (42 U.S.C.
10 1396u–3) is amended by striking subsections (b) and (e).

11 (c) **ELIMINATING ALLOCATIONS.**—Section 1933 of
12 the Social Security Act (42 U.S.C. 1396u–3) is amended
13 by striking subsections (c) and (g).

14 (d) **CONFORMING AMENDMENTS.**—

15 (1) **IN GENERAL.**—Section 1933 of the Social
16 Security Act (42 U.S.C. 1396u–3), as amended by
17 subsections (b) and (c), is further amended—

18 (A) by striking subsection (a) and insert-
19 ing the following new subsection:

20 “(a) **APPLICABLE FMAP.**—With respect to assist-
21 ance described in section 1902(a)(10)(E)(iv) furnished in
22 a State, the Federal medical assistance percentage shall
23 be equal to 100 percent.”;

24 (B) by striking subsection (d); and

1 (C) by redesignating subsection (f) as sub-
2 section (b).

3 (2) DEFINITION OF FMAP.—Section 1905(b) of
4 the Social Security Act (42 U.S.C. 1396d(b)) is
5 amended by striking “section 1933(d)” and insert-
6 ing “section 1933(a)”.

7 (e) EFFECTIVE DATE.—The amendments made by
8 this section shall take effect on April 1, 2014, and shall
9 apply with respect to calendar quarters beginning on or
10 after such date.

11 **SEC. 212. TRANSITIONAL MEDICAL ASSISTANCE.**

12 (a) EXTENSION.—Sections 1902(e)(1)(B) and
13 1925(f) of the Social Security Act (42 U.S.C.
14 1396a(e)(1)(B), 1396r–6(f)) are each amended by strik-
15 ing “March 31, 2014” and inserting “December 31,
16 2018”.

17 (b) OPT-OUT OPTION FOR STATES THAT EXPAND
18 ADULT COVERAGE AND PROVIDE 12-MONTH CONTINUOUS
19 ELIGIBILITY UNDER MEDICAID AND CHIP.—

20 (1) IN GENERAL.—Section 1925 of the Social
21 Security Act (42 U.S.C. 1396r–6), as amended by
22 subsection (a), is further amended—

23 (A) in subsection (a)—

1 (i) in paragraph (1)(A), by striking
2 “paragraph (5)” and inserting “para-
3 graphs (5) and (6)”; and

4 (ii) by adding at the end the fol-
5 lowing:

6 “(6) OPT-OUT OPTION FOR STATES THAT EX-
7 PAND ADULT COVERAGE AND PROVIDE 12-MONTH
8 CONTINUOUS ELIGIBILITY UNDER MEDICAID AND
9 CHIP.—

10 “(A) IN GENERAL.—In the case of a State
11 described in subparagraph (B), the State may
12 elect through a State plan amendment to have
13 this section and sections 408(a)(11)(A),
14 1902(a)(52), 1902(e)(1), and 1931(c)(2) not
15 apply to the State.

16 “(B) STATE DESCRIBED.—A State is de-
17 scribed in this subparagraph if the State is one
18 of the 50 States or the District of Columbia
19 and—

20 “(i) has elected to provide medical as-
21 sistance to individuals under subclause
22 (VIII) of section 1902(a)(10)(A)(i);

23 “(ii) has elected under section
24 1902(e)(12)(A) the option to provide con-

1 tinuous eligibility for a 12-month period
2 for individuals under 19 years of age;

3 “(iii) has elected under section
4 1902(e)(12)(B) the option to provide con-
5 tinuous eligibility for a 12-month period
6 for all categories of individuals described in
7 that section; and

8 “(iv) has elected to apply section
9 1902(e)(12)(A) to the State child health
10 plan under title XXI.”; and

11 (B) in subsection (b)(1), by striking “sub-
12 section (a)(5)” and inserting “paragraphs (5)
13 and (6) of subsection (a)”.

14 (2) CONFORMING AMENDMENT TO 4-MONTH RE-
15 QUIREMENT.—Section 1902(e)(1) of the Social Se-
16 curity Act (42 U.S.C. 1396a(e)(1)), as amended by
17 subsection (a), is further amended—

18 (A) in subparagraph (B), by striking
19 “Subparagraph (A)” and inserting “Subject to
20 subparagraph (C), subparagraph (A)”;

21 (B) by adding at the end the following:

22 “(C) If a State has made an election under section
23 1925(a)(6), subparagraph (A) and section 1925 shall not
24 apply to the State.”.

1 (c) EXTENSION OF 12-MONTH CONTINUOUS ELIGI-
2 BILITY OPTION TO CERTAIN ADULT ENROLLEES UNDER
3 MEDICAID; CLARIFICATION OF APPLICATION TO CHIP.—

4 (1) IN GENERAL.—Section 1902(e)(12) of the
5 Social Security Act (42 U.S.C. 1396a(e)(12)) is
6 amended—

7 (A) by redesignating subparagraphs (A)
8 and (B) as clauses (i) and (ii), respectively;

9 (B) by inserting “(A)” after “(12)”; and

10 (C) by adding at the end the following:

11 “(B) At the option of the State, the plan may provide
12 that an individual who is determined to be eligible for ben-
13 efits under a State plan approved under this title under
14 any of the following eligibility categories, or who is rede-
15 termined to be eligible for such benefits under any of such
16 categories, shall be considered to meet the eligibility re-
17 quirements met on the date of application and shall re-
18 main eligible for those benefits until the end of the 12-
19 month period following the date of the determination or
20 redetermination of eligibility:

21 “(i) Section 1902(a)(10)(A)(i)(VIII).

22 “(ii) Section 1931.”.

23 (2) APPLICATION TO CHIP.—Section 2107(e)(1)
24 of the Social Security Act (42 U.S.C. 1397gg(e)(1))
25 is amended—

1 (A) by redesignating subparagraphs (E)
 2 through (O) as subparagraphs (F) through (P),
 3 respectively; and

4 (B) by inserting after subparagraph (D),
 5 the following:

6 “(E) Section 1902(e)(12)(A) (relating to
 7 the State option for 12-month continuous eligi-
 8 bility and enrollment).”.

9 (d) CONFORMING AND TECHNICAL AMENDMENTS
 10 RELATING TO SECTION 1931 TRANSITIONAL COVERAGE
 11 REQUIREMENTS.—

12 (1) IN GENERAL.—Section 1931(c) of the So-
 13 cial Security Act (42 U.S.C. 1396u–1(c)) is amend-
 14 ed—

15 (A) in paragraph (1)—

16 (i) in the paragraph heading, by strik-
 17 ing “CHILD” and inserting “SPOUSAL”;

18 (ii) by striking “The provisions” and
 19 inserting “Subject to paragraph (3), the
 20 provisions”; and

21 (iii) by striking “child or”;

22 (B) in paragraph (2), by striking “For
 23 continued” and inserting “Subject to paragraph
 24 (3), for continued”; and

25 (C) by adding at the end the following:

1 “(3) OPT-OUT OPTION FOR STATES THAT EX-
2 PAND ADULT COVERAGE AND PROVIDE 12-MONTH
3 CONTINUOUS ELIGIBILITY UNDER MEDICAID AND
4 CHIP.—

5 “(A) IN GENERAL.—In the case of a State
6 described in subparagraph (B), the State may
7 elect through a State plan amendment to have
8 paragraphs (1) and (2) of this subsection and
9 sections 408(a)(11), 1902(a)(52), 1902(e)(1),
10 and 1925 not apply to the State.

11 “(B) STATE DESCRIBED.—A State is de-
12 scribed in this subparagraph if the State is one
13 of the 50 States or the District of Columbia
14 and—

15 “(i) has elected to provide medical as-
16 sistance to individuals under subclause
17 (VIII) of section 1902(a)(10)(A)(i);

18 “(ii) has elected under section
19 1902(e)(12)(A) the option to provide con-
20 tinuous eligibility for a 12-month period
21 for individuals under 19 years of age;

22 “(iii) has elected under section
23 1902(e)(12)(B) the option to provide con-
24 tinuous eligibility for a 12-month period

1 for all categories of individuals described in
2 that section; and

3 “(iv) has elected to apply section
4 1902(e)(12)(A) to the State child health
5 plan under title XXI.”.

6 (2) CONFORMING AMENDMENT TO SECTION
7 408.—Section 408(a)(11) of the Social Security Act
8 (42 U.S.C. 608(a)(11) is amended—

9 (A) in the paragraph heading, by striking
10 “CHILD” and inserting “SPOUSAL”; and

11 (B) in subparagraph (B)—

12 (i) in the subparagraph heading, by
13 striking “CHILD” and inserting “SPOUS-
14 AL”; and

15 (ii) by striking “child or”.

16 (e) CONFORMING AMENDMENT RELATING TO MAIN-
17 TENANCE OF EFFORT FOR CHILDREN.—Section
18 1902(gg)(4) of the Social Security Act (42 U.S.C.
19 1396a(gg)(4)) is amended by adding at the end the fol-
20 lowing:

21 “(C) STATES THAT EXPAND ADULT COV-
22 ERAGE AND ELECT TO OPT-OUT OF TRANSI-
23 TIONAL COVERAGE.—

24 “(i) IN GENERAL.—For purposes of
25 determining compliance with the require-

1 ments of paragraph (2), a State which ex-
2 ercises the option under sections
3 1925(a)(6) and 1931(c)(3) to provide no
4 transitional medical assistance or other ex-
5 tended eligibility (as applicable) shall not,
6 as a result of exercising such option, be
7 considered to have in effect eligibility
8 standards, methodologies, or procedures
9 described in clause (ii) that are more re-
10 strictive than the standards, methodolo-
11 gies, or procedures in effect under the
12 State plan or under a waiver of the plan
13 on the date of enactment of the Patient
14 Protection and Affordable Care Act.

15 “(ii) STANDARDS, METHODOLOGIES,
16 OR PROCEDURES DESCRIBED.—The eligi-
17 bility standards, methodologies, or proce-
18 dures described in this clause are those
19 standards, methodologies, or procedures
20 applicable to determining the eligibility for
21 medical assistance of any child under 19
22 years of age (or such higher age as the
23 State may have elected).”.

24 (f) EFFECTIVE DATE.—The amendments made by
25 this section shall take effect on April 1, 2014.

1 **SEC. 213. EXPRESS LANE ELIGIBILITY.**

2 Section 1902(e)(13)(I) of the Social Security Act (42
3 U.S.C. 1396a(e)(13)(I)) is amended by striking “Sep-
4 tember 30, 2014” and inserting “September 30, 2015”.

5 **SEC. 214. PEDIATRIC QUALITY MEASURES.**

6 (a) CONTINUATION OF FUNDING FOR PEDIATRIC
7 QUALITY MEASURES FOR IMPROVING THE QUALITY OF
8 CHILDREN’S HEALTH CARE.—Section 1139B(e) of the
9 Social Security Act (42 U.S.C. 1320b–9b(e)) is amended
10 by adding at the end the following: “Of the funds appro-
11 priated under this subsection, not less than \$15,000,000
12 shall be used to carry out section 1139A(b).”.

13 (b) ELIMINATION OF RESTRICTION ON MEDICAID
14 QUALITY MEASUREMENT PROGRAM.—Section
15 1139B(b)(5)(A) of the Social Security Act (42 U.S.C.
16 1320b–9b(b)(5)(A)) is amended by striking “The aggre-
17 gate amount awarded by the Secretary for grants and con-
18 tracts for the development, testing, and validation of
19 emerging and innovative evidence-based measures under
20 such program shall equal the aggregate amount awarded
21 by the Secretary for grants under section
22 1139A(b)(4)(A)”.

23 **SEC. 215. SPECIAL DIABETES PROGRAMS.**

24 (a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-
25 BETES.—Section 330B(b)(2)(C) of the Public Health

1 Service Act (42 U.S.C. 254e-2(b)(2)(C)) is amended by
2 striking “2014” and inserting “2019”.

3 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—
4 Section 330C(c)(2)(C) of the Public Health Service Act
5 (42 U.S.C. 254e-3(c)(2)(C)) is amended by striking
6 “2014” and inserting “2019”.

7 **Subtitle C—Human Services** 8 **Extensions**

9 **SEC. 221. ABSTINENCE EDUCATION GRANTS.**

10 (a) IN GENERAL.—Section 510 of the Social Security
11 Act (42 U.S.C. 710) is amended—

12 (1) in subsection (a), in the matter preceding
13 paragraph (1), by striking “2010 through 2014”
14 and inserting “2015 through 2019”; and

15 (2) in subsection (d)—

16 (A) by striking “2010 through 2014” and
17 inserting “2015 through 2019”; and

18 (B) by striking the second sentence.

19 (b) EFFECTIVE DATE.—The amendments made by
20 this section shall take effect on October 1, 2014.

21 **SEC. 222. PERSONAL RESPONSIBILITY EDUCATION PRO-** 22 **GRAM.**

23 (a) IN GENERAL.—Section 513 of the Social Security
24 Act (42 U.S.C. 713) is amended—

25 (1) in subsection (a)—

1 (A) in paragraph (1)(A), by striking “2010
2 through 2014” and inserting “2015 through
3 2019”;

4 (B) in paragraph (4)—

5 (i) in subparagraph (A)—

6 (I) by striking “2010 or 2011”
7 and inserting “2015 or 2016”;

8 (II) by striking “2010 through
9 2014” and inserting “2015 through
10 2019”; and

11 (III) by striking “2012 through
12 2014” and inserting “2017 through
13 2019”; and

14 (ii) in subparagraph (B)(i)—

15 (I) by striking “2012, 2013, and
16 2014” and inserting “2017, 2018,
17 and 2019”; and

18 (II) by striking “2010 or 2011”
19 and inserting “2015 or 2016”; and

20 (C) in paragraph (5), by striking “2009”
21 and inserting “2014”;

22 (2) in subsection (b)(2)(A), in the matter pre-
23 ceding clause (i), by inserting “and youth at risk of
24 becoming victims of sex trafficking (as defined in
25 section 103(10) of the Trafficking Victims Protec-

1 tion Act of 2000 (22 U.S.C. 7102(10))) or victims
2 of a severe form of trafficking in persons described
3 in paragraph (9)(A) of that Act (22 U.S.C.
4 7102(9)(A))” after “adolescents”;

5 (3) in subsection(c)(1), by inserting “youth at
6 risk of becoming victims of sex trafficking (as de-
7 fined in section 103(10) of the Trafficking Victims
8 Protection Act of 2000 (22 U.S.C. 7102(10))) or
9 victims of a severe form of trafficking in persons de-
10 scribed in paragraph (9)(A) of that Act (22 U.S.C.
11 7102(9)(A)),” after “youth in foster care,”; and

12 (4) in subsection (f), by striking “2010 through
13 2014” and inserting “2015 through 2019”.

14 (b) EFFECTIVE DATE.—The amendments made by
15 this section shall take effect on October 1, 2014.

16 **SEC. 223. FAMILY-TO-FAMILY HEALTH INFORMATION CEN-**
17 **TERS.**

18 (a) IN GENERAL.—Section 501(c) of the Social Secu-
19 rity Act (42 U.S.C. 701(c)) is amended—

20 (1) in paragraph (1)(A), by striking clause (iv)
21 and inserting the following:

22 “(iv) \$6,000,000 for each of fiscal
23 years 2014 through 2018.”; and

24 (2) by striking paragraph (5).

1 (b) PREVENTION OF DUPLICATE APPROPRIATIONS
 2 FOR FISCAL YEAR 2014.—Expenditures made for fiscal
 3 year 2014 pursuant to section 501(c)(iv) of the Social Se-
 4 curity Act (42 U.S.C. 701(c)(iv)), as amended by section
 5 1203 of division B of the Bipartisan Budget Act of 2013
 6 (Public Law 113–67), shall be charged to the appropria-
 7 tion for that fiscal year provided by the amendments made
 8 by this section.

9 **SEC. 224. HEALTH WORKFORCE DEMONSTRATION PROJECT**
 10 **FOR LOW-INCOME INDIVIDUALS.**

11 Section 2008(c)(1) of the Social Security Act (42
 12 U.S.C. 1397g(c)(1)) is amended by striking “ through
 13 2014” and inserting “2012, and only to carry out sub-
 14 section (a), \$85,000,000 for each of fiscal years 2013
 15 through 2016”.

16 **TITLE III—MEDICARE AND**
 17 **MEDICAID PROGRAM INTEGRITY**

18 **SEC. 301. REDUCING IMPROPER MEDICARE PAYMENTS.**

19 (a) MEDICARE ADMINISTRATIVE CONTRACTOR IM-
 20 PROPER PAYMENT OUTREACH AND EDUCATION PRO-
 21 GRAM.—

22 (1) IN GENERAL.—Section 1874A of the Social
 23 Security Act (42 U.S.C. 1395kk–1) is amended—

24 (A) in subsection (a)(4)—

1 (i) by redesignating subparagraph (G)
2 as subparagraph (H); and

3 (ii) by inserting after subparagraph
4 (F) the following new subparagraph:

5 “(G) IMPROPER PAYMENT OUTREACH AND
6 EDUCATION PROGRAM.—Having in place an im-
7 proper payment outreach and education pro-
8 gram described in subsection (h).”;

9 (B) by adding at the end the following new
10 subsection:

11 “(h) IMPROPER PAYMENT OUTREACH AND EDU-
12 CATION PROGRAM.—

13 “(1) IN GENERAL.—In order to reduce im-
14 proper payments under this title, each medicare ad-
15 ministrative contractor shall establish and have in
16 place an improper payment outreach and education
17 program under which the contractor, through out-
18 reach, education, training, and technical assistance
19 activities, shall provide providers of services and sup-
20 pliers located in the region covered by the contract
21 under this section with the information described in
22 paragraph (3). The activities described in the pre-
23 ceding sentence shall be conducted on a regular
24 basis.

1 “(2) FORMS OF OUTREACH, EDUCATION, TRAIN-
2 ING, AND TECHNICAL ASSISTANCE ACTIVITIES.—The
3 outreach, education, training, and technical assist-
4 ance activities under a payment outreach and edu-
5 cation program shall be carried out through any of
6 the following:

7 “(A) Emails and other electronic commu-
8 nications.

9 “(B) Webinars.

10 “(C) Telephone calls.

11 “(D) In-person training.

12 “(E) Other forms of communications de-
13 termined appropriate by the Secretary.

14 “(3) INFORMATION TO BE PROVIDED THROUGH
15 ACTIVITIES.—The information to be provided to pro-
16 viders of services and suppliers under a payment
17 outreach and education program shall include all of
18 the following information:

19 “(A) A list of the provider’s or supplier’s
20 most frequent and expensive payment errors
21 over the last quarter.

22 “(B) Specific instructions regarding how to
23 correct or avoid such errors in the future.

24 “(C) A notice of all new topics that have
25 been approved by the Secretary for audits con-

1 ducted by recovery audit contractors under sec-
2 tion 1893(h).

3 “(D) Specific instructions to prevent fu-
4 ture issues related to such new audits.

5 “(E) Other information determined appro-
6 priate by the Secretary.

7 “(4) ERROR RATE REDUCTION TRAINING.—

8 “(A) IN GENERAL.—The activities under a
9 payment outreach and education program shall
10 include error rate reduction training.

11 “(B) REQUIREMENTS.—

12 “(i) IN GENERAL.—The training de-
13 scribed in subparagraph (A) shall—

14 “(I) be provided at least annu-
15 ally; and

16 “(II) focus on reducing the im-
17 proper payments described in para-
18 graph (5).

19 “(C) INVITATION.—A medicare adminis-
20 trative contractor shall ensure that all providers
21 of services and suppliers located in the region
22 covered by the contract under this section are
23 invited to attend the training described in sub-
24 paragraph (A) either in person or online.

1 “(5) PRIORITY.—A medicare administrative
2 contractor shall give priority to activities under the
3 improper payment outreach and education program
4 that will reduce improper payments for items and
5 services that—

6 “(A) have the highest rate of improper
7 payment;

8 “(B) have the greatest total dollar amount
9 of improper payments;

10 “(C) are due to clear misapplication or
11 misinterpretation of Medicare policies;

12 “(D) are clearly due to common and inad-
13 vertent clerical or administrative errors; or

14 “(E) are due to other types of errors that
15 the Secretary determines could be prevented
16 through activities under the program.

17 “(6) INFORMATION ON IMPROPER PAYMENTS
18 FROM RECOVERY AUDIT CONTRACTORS.—

19 “(A) IN GENERAL.—In order to assist
20 medicare administrative contractors in carrying
21 out improper payment outreach and education
22 programs, the Secretary shall provide each con-
23 tractor with a complete list of improper pay-
24 ments identified by recovery audit contractors
25 under section 1893(h) with respect to providers

1 of services and suppliers located in the region
2 covered by the contract under this section. Such
3 information shall be provided on a quarterly
4 basis.

5 “(B) INFORMATION.—The information de-
6 scribed in subparagraph (A) shall include the
7 following information:

8 “(i) The providers of services and
9 suppliers that have the highest rate of im-
10 proper payments.

11 “(ii) The providers of services and
12 suppliers that have the greatest total dollar
13 amounts of improper payments.

14 “(iii) The items and services furnished
15 in the region that have the highest rates of
16 improper payments.

17 “(iv) The items and services furnished
18 in the region that are responsible for the
19 greatest total dollar amount of improper
20 payments.

21 “(v) Other information the Secretary
22 determines would assist the contractor in
23 carrying out the improper payment out-
24 reach and education program.

1 “(C) FORMAT OF INFORMATION.—The in-
2 formation furnished to medicare administrative
3 contractors by the Secretary under this para-
4 graph shall be transmitted in a manner that
5 permits the contractor to easily identify the
6 areas of the Medicare program in which tar-
7 geted outreach, education, training, and tech-
8 nical assistance would be most effective. In car-
9 rying out the preceding sentence, the Secretary
10 shall ensure that—

11 “(i) the information with respect to
12 improper payments made to a provider of
13 services or supplier clearly displays the
14 name and address of the provider or sup-
15 plier, the amount of the improper payment,
16 and any other information the Secretary
17 determines appropriate; and

18 “(ii) the information is in an elec-
19 tronic, easily searchable database.

20 “(7) COMMUNICATIONS.—All communications
21 with providers of services and suppliers under a pay-
22 ment outreach and education program are subject to
23 the standards and requirements of subsection (g).

24 “(8) FUNDING.—After application of paragraph
25 (1)(C) of section 1893(h), the Secretary shall retain

1 a portion of the amounts recovered by recovery audit
 2 contractors under such section which shall be avail-
 3 able to the program management account of the
 4 Centers for Medicare & Medicaid Services for pur-
 5 poses of carrying out this subsection and to imple-
 6 ment corrective actions to help reduce the error rate
 7 of payments under this title. The amount retained
 8 under the preceding sentence shall not exceed an
 9 amount equal to 25 percent of the amounts recov-
 10 ered under section 1893(h).”.

11 (2) FUNDING CONFORMING AMENDMENT.—Sec-
 12 tion 1893(h)(2) of the Social Security Act (42
 13 U.S.C. 1395ddd(h)(2)) is amended by inserting “or
 14 section 1874(h)(8)” after “paragraph (1)(C)”.

15 (3) EFFECTIVE DATE.—The amendments made
 16 by this subsection take effect on January 1, 2015.

17 (b) TRANSPARENCY.—Section 1893(h)(8) of the So-
 18 cial Security Act (42 U.S.C. 1395ddd(h)(8)) is amended—

19 (1) by striking “REPORT.—The Secretary” and
 20 inserting “REPORT.—

21 “(A) IN GENERAL.—The Secretary”; and

22 (2) by adding at the end the following new sub-
 23 paragraph:

24 “(B) INCLUSION OF CERTAIN INFORMA-
 25 TION.—

1 “(i) IN GENERAL.—For reports sub-
2 mitted under this paragraph for 2015 or a
3 subsequent year, each such report shall in-
4 clude the information described in clause
5 (ii) with respect to each of the following
6 categories of audits carried out by recovery
7 audit contractors under this subsection:

8 “(I) Automated.

9 “(II) Complex.

10 “(III) Medical necessity review.

11 “(IV) Part A.

12 “(V) Part B.

13 “(VI) Durable medical equip-
14 ment.

15 “(ii) INFORMATION DESCRIBED.—For
16 purposes of clause (i), the information de-
17 scribed in this clause, with respect to a
18 category of audit described in clause (i), is
19 the result of all appeals for each individual
20 level of appeals in such category.”.

21 (c) RECOVERY AUDIT CONTRACTOR DEMONSTRA-
22 TION PROJECT.—

23 (1) IN GENERAL.—The Secretary shall conduct
24 a demonstration project under title XVIII of the So-
25 cial Security Act that—

1 (A) targets audits by recovery audit con-
2 tractors under section 1893(h) of the Social Se-
3 curity Act (42 U.S.C. 1395ddd(h)) with respect
4 to high error providers of services and suppliers
5 identified under paragraph (3); and

6 (B) rewards low error providers of services
7 and suppliers identified under such paragraph.

8 (2) SCOPE.—

9 (A) DURATION.—The demonstration
10 project shall be implemented not later than
11 January 1, 2015, and shall be conducted for a
12 period of three years.

13 (B) DEMONSTRATION AREA.—In deter-
14 mining the geographic area of the demonstra-
15 tion project, the Secretary shall consider the
16 following:

17 (i) The total number of providers of
18 services and suppliers in the region.

19 (ii) The diversity of types of providers
20 of services and suppliers in the region.

21 (iii) The level and variation of im-
22 proper payment rates of and among indi-
23 vidual providers of services and suppliers
24 in the region.

1 (iv) The inclusion of a mix of both
2 urban and rural areas.

3 (3) IDENTIFICATION OF LOW ERROR AND HIGH
4 ERROR PROVIDERS OF SERVICES AND SUPPLIERS.—

5 (A) IN GENERAL.—In conducting the dem-
6 onstration project, the Secretary shall identify
7 the following two groups of providers in accord-
8 ance with this paragraph:

9 (i) Low error providers of services and
10 suppliers.

11 (ii) High error providers of services
12 and suppliers.

13 (B) ANALYSIS.—For purposes of identi-
14 fying the groups under subparagraph (A), the
15 Secretary shall analyze the following as they re-
16 late to the total number and amount of claims
17 submitted in the area and by each provider:

18 (i) The improper payment rates of in-
19 dividual providers of services and suppliers.

20 (ii) The amount of improper payments
21 made to individual providers of services
22 and suppliers.

23 (iii) The frequency of errors made by
24 the provider of services or supplier over
25 time.

1 (iv) Other information determined ap-
2 propriate by the Secretary.

3 (C) ASSIGNMENT BASED ON COMPOSITE
4 SCORE.—The Secretary shall assign selected
5 providers of services and suppliers under the
6 demonstration program based on a composite
7 score determined using the analysis under sub-
8 paragraph (B) as follows:

9 (i) Providers of services and suppliers
10 with high, expensive, and frequent errors
11 shall receive a high score and be identified
12 as high error providers of services and sup-
13 pliers under subparagraph (A).

14 (ii) Providers of services and suppliers
15 with few, inexpensive, and infrequent er-
16 rors shall receive a low score and be identi-
17 fied as low error providers of services and
18 suppliers under such subparagraph.

19 (iii) Only a small proportion of the
20 total providers of services and suppliers
21 and individual types of providers of serv-
22 ices and suppliers in the geographic area
23 of the demonstration project shall be as-
24 signed to either group identified under
25 such subparagraph.

1 (D) TIMEFRAME OF IDENTIFICATION.—

2 (i) IN GENERAL.—Any identification
3 of a provider of services or a supplier
4 under subparagraph (A) shall be for a pe-
5 riod of 12 months.

6 (ii) REEVALUATION.—The Secretary
7 shall reevaluate each such identification at
8 the end of such period.

9 (iii) USE OF MOST CURRENT INFOR-
10 MATION.—In carrying out the reevaluation
11 under clause (ii) with respect to a provider
12 of services or supplier, the Secretary
13 shall—

14 (I) consider the most current in-
15 formation available with respect to the
16 provider of services or supplier under
17 the analysis under subparagraph (B);
18 and

19 (II) take into account improve-
20 ment or regression of the provider of
21 services or supplier.

22 (4) ADJUSTMENT OF RECORD REQUEST MAX-
23 IMUM.—Under the demonstration project, the Sec-
24 retary shall establish procedures to—

1 (A) increase the maximum record request
2 made by recovery audit contractors to providers
3 of services and suppliers identified as high error
4 providers of services and suppliers under para-
5 graph (3); and

6 (B) decrease the maximum record request
7 made by recovery audit contractors to providers
8 of services and suppliers identified as low error
9 providers of services and supplier under such
10 paragraph.

11 (5) ADDITIONAL ADJUSTMENTS.—

12 (A) IN GENERAL.—Under the demonstra-
13 tion project, the Secretary may make additional
14 adjustments to requirements for recovery audit
15 contractors under section 1893(h) of the Social
16 Security Act (42 U.S.C. 1395ddd(h)) and the
17 conduct of audits with respect to low error pro-
18 viders of services and suppliers identified under
19 paragraph (3) and high error providers of serv-
20 ices and suppliers identified under such para-
21 graph as the Secretary determines necessary in
22 order to incentivize reductions in improper pay-
23 ment rates under title XVIII of such Act (42
24 U.S.C. 1395 et seq.).

1 (B) LIMITATION.—The Secretary shall not
2 exempt any group of providers of services or
3 suppliers in the demonstration project from
4 being subject to audit by a recovery audit con-
5 tractor under such section 1893(h).

6 (6) EVALUATION AND REPORT.—

7 (A) EVALUATION.—The Inspector General
8 of the Department of Health and Human Serv-
9 ices shall conduct an evaluation of the dem-
10 onstration project under this subsection. The
11 evaluation shall include an analysis of—

12 (i) the error rates of providers of serv-
13 ices and suppliers—

14 (I) identified under paragraph
15 (3) as low error providers of services
16 and suppliers;

17 (II) identified under such para-
18 graph as high error providers of serv-
19 ices and suppliers; and

20 (III) that are located in the geo-
21 graphic area of the demonstration
22 project and are not identified as either
23 a low error or high error provider of
24 services or supplier under such para-
25 graph; and

1 (ii) any improvements in the error
2 rates of those high error providers of serv-
3 ices and suppliers identified under such
4 paragraph.

5 (B) REPORT.—Not later than 12 months
6 after completion of the demonstration project,
7 the Inspector General shall submit to Congress
8 a report containing the results of the evaluation
9 conducted under subparagraph (A), together
10 with recommendations on whether the dem-
11 onstration project should be continued or ex-
12 panded, including on a permanent or nation-
13 wide basis.

14 (7) FUNDING.—

15 (A) FUNDING FOR IMPLEMENTATION.—
16 For purposes of carrying out the demonstration
17 project under this subsection (other than the
18 evaluation and report under paragraph (6)), the
19 Secretary shall provide for the transfer, from
20 the Federal Hospital Insurance Trust Fund
21 under section 1817 (42 U.S.C. 1395i) and the
22 Federal Supplementary Medical Insurance
23 Trust Fund under section 1841 (42 U.S.C.
24 1395t), in such proportion as the Secretary de-
25 termines appropriate, of \$10,000,000 to the

1 Centers for Medicare & Medicaid Services Pro-
2 gram Management Account.

3 (B) FUNDING FOR INSPECTOR GENERAL
4 EVALUATION AND REPORT.—For purposes of
5 carrying out the evaluation and report under
6 paragraph (6), the Secretary shall provide for
7 the transfer, from the Federal Hospital Insur-
8 ance Trust Fund under such section 1817 and
9 the Federal Supplementary Medical Insurance
10 Trust Fund under such section 1841, in such
11 proportion as the Secretary determines appro-
12 priate, of \$245,000 to the Inspector General of
13 the Department of Health and Human Services.

14 (C) AVAILABILITY.—Amounts transferred
15 under subparagraph (A) or (B) shall remain
16 available until expended.

17 (8) DEFINITIONS.—In this section:

18 (A) DEMONSTRATION PROJECT.—The term
19 “demonstration project” means the demonstra-
20 tion project under this subsection.

21 (B) PROVIDER OF SERVICES.—The term
22 “provider of services” has the meaning given
23 that term in section 1861(u).

24 (C) RECOVERY AUDIT CONTRACTOR.—The
25 term “recovery audit contractor” means an en-

1 tity with a contract under section 1893(h) of
 2 the Social Security Act (42 U.S.C.
 3 1395ddd(h)).

4 (D) SECRETARY.—The term “Secretary”
 5 means the Secretary of Health and Human
 6 Services.

7 (E) SUPPLIER.—The term “supplier” has
 8 the meaning given that term in section 1861(d).

9 **SEC. 302. AUTHORITY FOR MEDICAID FRAUD CONTROL**
 10 **UNITS TO INVESTIGATE AND PROSECUTE**
 11 **COMPLAINTS OF ABUSE AND NEGLECT OF**
 12 **MEDICAID PATIENTS IN HOME AND COMMU-**
 13 **NITY-BASED SETTINGS.**

14 (a) IN GENERAL.—Section 1903(q)(4)(A) of the So-
 15 cial Security Act (42 U.S.C. 1396b(q)(4)(A)) is amended
 16 to read as follows:

17 “(4)(A) The entity’s function includes a state-
 18 wide program for the—

19 “(i) investigation and prosecution, or refer-
 20 ral for prosecution or other action, of com-
 21 plaints of abuse or neglect of patients in health
 22 care facilities which receive payments under the
 23 State plan under this title or under a waiver of
 24 such plan;

1 “(ii) at the option of the entity, investiga-
 2 tion and prosecution, or referral for prosecution
 3 or other action, of complaints of abuse or ne-
 4 glect of individuals in connection with any as-
 5 pect of the provision of medical assistance and
 6 the activities of providers of such assistance in
 7 a home or community based setting that is paid
 8 for under the State plan under this title or
 9 under a waiver of such plan; and

10 “(iii) at the option of the entity, investiga-
 11 tion and prosecution, or referral for prosecution
 12 or other action, of complaints of abuse or ne-
 13 glect of patients residing in board and care fa-
 14 cilities.”.

15 (b) **EFFECTIVE DATE.**—The amendment made by
 16 subsection (a) shall take effect on January 1, 2015.

17 **SEC. 303. IMPROVED USE OF FUNDS RECEIVED BY THE HHS**
 18 **INSPECTOR GENERAL FROM OVERSIGHT AND**
 19 **INVESTIGATIVE ACTIVITIES.**

20 (a) **IN GENERAL.**—Section 1128C(b) of the Social
 21 Security Act (42 U.S.C. 1320a–7c(b)) is amended to read
 22 as follows:

23 “(b) **ADDITIONAL USE OF FUNDS BY INSPECTOR**
 24 **GENERAL.**—

1 “(1) COLLECTIONS FROM MEDICARE AND MED-
2 ICAID RECOVERY ACTIONS.—Notwithstanding section
3 3302 of title 31, United States Code, or any other
4 provision of law affecting the crediting of collections,
5 the Inspector General of the Department of Health
6 and Human Services may receive and retain for cur-
7 rent use three percent of all amounts collected pur-
8 suant to civil debt collection and administrative en-
9 forcement actions related to false claims or frauds
10 involving the Medicare program under title XVIII or
11 the Medicaid program under title XIX.

12 “(2) CREDITING.—Funds received by the In-
13 spector General under paragraph (1) shall be depos-
14 ited as offsetting collections to the credit of any ap-
15 propriation available for oversight and enforcement
16 activities of the Inspector General permitted under
17 subsection (a), and shall remain available until ex-
18 pended.”.

19 (b) EFFECTIVE DATE.—The amendment made by
20 subsection (a) shall apply to funds received from settle-
21 ments finalized, judgments entered, or final agency deci-
22 sions issued, on or after the date of the enactment of this
23 Act.

1 **SEC. 304. PREVENTING AND REDUCING IMPROPER MEDI-**
2 **CARE AND MEDICAID EXPENDITURES.**

3 (a) **REQUIRING VALID PRESCRIBER NATIONAL PRO-**
4 **VIDER IDENTIFIERS ON PHARMACY CLAIMS.**—Section
5 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–
6 104(c)) is amended by adding at the end the following new
7 paragraph:

8 “(4) **REQUIRING VALID PRESCRIBER NATIONAL**
9 **PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.**—

10 “(A) **IN GENERAL.**—For plan year 2015
11 and subsequent plan years, subject to subpara-
12 graph (B), the Secretary shall prohibit PDP
13 sponsors of prescription drug plans from paying
14 claims for prescription drugs under this part
15 that do not include a valid prescriber National
16 Provider Identifier.

17 “(B) **PROCEDURES.**—The Secretary shall
18 establish procedures for determining the validity
19 of prescriber National Provider Identifiers
20 under subparagraph (A).

21 “(C) **REPORT.**—Not later than January 1,
22 2017, the Inspector General of the Department
23 of Health and Human Services shall submit to
24 Congress a report on the effectiveness of the
25 procedures established under subparagraph
26 (B).”.

1 (b) REFORMING HOW CMS TRACKS AND CORRECTS
2 THE VULNERABILITIES IDENTIFIED BY RECOVERY AUDIT
3 CONTRACTORS.—Section 1893(h) of the Social Security
4 Act (42 U.S.C. 1395ddd(h)) is amended—

5 (1) in paragraph (8), as amended by section
6 301, by adding at the end the following new sub-
7 paragraphs:

8 “(C) INCLUSION OF IMPROPER PAYMENT
9 VULNERABILITIES IDENTIFIED.—For reports
10 submitted under this paragraph for 2015 or a
11 subsequent year, each such report shall in-
12 clude—

13 “(i) a description of—

14 “(I) the types and financial cost
15 to the program under this title of im-
16 proper payment vulnerabilities identi-
17 fied by recovery audit contractors
18 under this subsection; and

19 “(II) how the Secretary is ad-
20 dressing such improper payment
21 vulnerabilities; and

22 “(ii) an assessment of the effective-
23 ness of changes made to payment policies
24 and procedures under this title in order to
25 address the vulnerabilities so identified.

1 “(D) LIMITATION.—The Secretary shall
2 ensure that each report submitted under sub-
3 paragraph (A) does not include information
4 that the Secretary determines would be sen-
5 sitive or would otherwise negatively impact pro-
6 gram integrity.”; and

7 (2) by adding at the end the following new
8 paragraph:

9 “(10) ADDRESSING IMPROPER PAYMENT
10 VULNERABILITIES.—The Secretary shall address im-
11 proper payment vulnerabilities identified by recovery
12 audit contractors under this subsection in a timely
13 manner, prioritized based on the risk to the program
14 under this title.”.

15 (c) STRENGTHENING MEDICAID PROGRAM INTEG-
16 RITY THROUGH FLEXIBILITY.—Section 1936 of the Social
17 Security Act (42 U.S.C. 1396u–6) is amended—

18 (1) in subsection (a), by inserting “, or other-
19 wise,” after “entities”; and

20 (2) in subsection (e)—

21 (A) in paragraph (1), in the matter pre-
22 ceding subparagraph (A), by inserting “(includ-
23 ing the costs of equipment, salaries and bene-
24 fits, and travel and training)” after “Program
25 under this section”; and

1 (B) in paragraph (3), by striking “by 100”
2 and inserting “by 100, or such number as de-
3 termined necessary by the Secretary to carry
4 out the Program under this section,”.

5 (d) ACCESS TO THE NATIONAL DIRECTORY OF NEW
6 HIRES.—Section 453(j) of the Social Security Act (42
7 U.S.C. 653(j)) is amended by adding at the end the fol-
8 lowing new paragraph:

9 “(12) INFORMATION COMPARISONS AND DIS-
10 CLOSURES TO ASSIST IN ADMINISTRATION OF THE
11 MEDICARE PROGRAM AND STATE HEALTH SUBSIDY
12 PROGRAMS.—

13 “(A) DISCLOSURE TO THE ADMINIS-
14 TRATOR OF THE CENTERS FOR MEDICARE &
15 MEDICAID SERVICES.—The Administrator of
16 the Centers for Medicare & Medicaid shall have
17 access to the information in the National Direc-
18 tory of New Hires for purposes of determining
19 the eligibility of an applicant for, or enrollee in,
20 the Medicare program under title XVIII or an
21 applicable State health subsidy program (as de-
22 fined in section 1413(e) of the Patient Protec-
23 tion and Affordable Care Act (42 U.S.C.
24 18083(e)).

1 “(B) DISCLOSURE TO THE INSPECTOR
2 GENERAL OF THE DEPARTMENT OF HEALTH
3 AND HUMAN SERVICES.—

4 “(i) IN GENERAL.—If the Inspector
5 General of the Department of Health and
6 Human Services transmits to the Secretary
7 the names and social security account
8 numbers of individuals, the Secretary shall
9 disclose to the Inspector General informa-
10 tion on such individuals and their employ-
11 ers maintained in the National Directory
12 of New Hires.

13 “(ii) USE OF INFORMATION.—The In-
14 spector General of the Department of
15 Health and Human Services may use in-
16 formation provided under clause (i) only
17 for purposes of —

18 “(I) enforcing mandatory and
19 permissive exclusions under title XI;
20 or

21 “(II) evaluating the integrity of
22 the Medicare program or an applica-
23 ble State health subsidy program (as
24 defined in section 1413(e) of the Pa-

1 tient Protection and Affordable Care
2 Act).

3 The authority under this clause is in addi-
4 tion to any authority conferred under the
5 Inspector General Act of 1978 (5 U.S.C.
6 App).

7 “(C) DISCLOSURE TO STATE AGENCIES.—

8 “(i) IN GENERAL.—If, for purposes of
9 determining the eligibility of an applicant
10 for, or an enrollee in, an applicable State
11 health subsidy program (as defined in sec-
12 tion 1413(e) of the Patient Protection and
13 Affordable Care Act (42 U.S.C. 18083(e)),
14 a State agency responsible for admin-
15 istering such program transmits to the
16 Secretary the names, dates of birth, and
17 social security account numbers of individ-
18 uals, the Secretary shall disclose to such
19 State agency information on such individ-
20 uals and their employers maintained in the
21 National Directory of New Hires, subject
22 to this subparagraph.

23 “(ii) CONDITION ON DISCLOSURE BY
24 THE SECRETARY.—The Secretary shall
25 make a disclosure under clause (i) only to

1 the extent that the Secretary determines
2 that the disclosure would not interfere with
3 the effective operation of the program
4 under this part.

5 “(iii) USE AND DISCLOSURE OF IN-
6 FORMATION BY STATE AGENCIES.—

7 “(I) IN GENERAL.—A State
8 agency may not use or disclose infor-
9 mation provided under clause (i) ex-
10 cept for purposes of determining the
11 eligibility of an applicant for, or an
12 enrollee in, a program referred to in
13 clause (i).

14 “(II) INFORMATION SECURITY.—
15 The State agency shall have in effect
16 data security and control policies that
17 the Secretary finds adequate to ensure
18 the security of information obtained
19 under clause (i) and to ensure that
20 access to such information is re-
21 stricted to authorized persons for pur-
22 poses of authorized uses and disclo-
23 sures.

24 “(III) PENALTY FOR MISUSE OF
25 INFORMATION.—An officer or em-

1 ployee of the State agency who fails to
2 comply with this clause shall be sub-
3 ject to the sanctions under subsection
4 (l)(2) to the same extent as if such of-
5 ficer or employee were an officer or
6 employee of the United States.

7 “(iv) PROCEDURAL REQUIREMENTS.—
8 State agencies requesting information
9 under clause (i) shall adhere to uniform
10 procedures established by the Secretary
11 governing information requests and data
12 matching under this paragraph.

13 “(v) REIMBURSEMENT OF COSTS.—
14 The State agency shall reimburse the Sec-
15 retary, in accordance with subsection
16 (k)(3), for the costs incurred by the Sec-
17 retary in furnishing the information re-
18 quested under this subparagraph.”.

19 (e) IMPROVING THE SHARING OF DATA BETWEEN
20 THE FEDERAL GOVERNMENT AND STATE MEDICAID PRO-
21 GRAMS.—

22 (1) IN GENERAL.—The Secretary of Health and
23 Human Services (in this subsection referred to as
24 the “Secretary”) shall establish a plan to encourage
25 and facilitate the participation of States in the Medi-

1 care-Medicaid Data Match Program (commonly re-
2 ferred to as the “Medi-Medi Program”) under sec-
3 tion 1893(g) of the Social Security Act (42 U.S.C.
4 1395ddd(g)).

5 (2) PROGRAM REVISIONS TO IMPROVE MEDI-
6 MEDI DATA MATCH PROGRAM PARTICIPATION BY
7 STATES.—Section 1893(g)(1)(A) of the Social Secu-
8 rity Act (42 U.S.C. 1395ddd(g)(1)(A)) is amend-
9 ed—

10 (A) in the matter preceding clause (i), by
11 inserting “or otherwise” after “eligible enti-
12 ties”;

13 (B) in clause (i)—

14 (i) by inserting “to review claims
15 data” after “algorithms”; and

16 (ii) by striking “service, time, or pa-
17 tient” and inserting “provider, service,
18 time, or patient”;

19 (C) in clause (ii)—

20 (i) by inserting “to investigate and re-
21 cover amounts with respect to suspect
22 claims” after “appropriate actions”; and

23 (ii) by striking “; and” and inserting
24 a semicolon;

1 (D) in clause (iii), by striking the period
2 and inserting “; and”; and

3 (E) by adding at end the following new
4 clause:

5 “(iv) furthering the Secretary’s de-
6 sign, development, installation, or enhance-
7 ment of an automated data system archi-
8 tecture—

9 “(I) to collect, integrate, and as-
10 sess data for purposes of program in-
11 tegrity, program oversight, and ad-
12 ministration, including the Medi-Medi
13 Program; and

14 “(II) that improves the coordina-
15 tion of requests for data from
16 States.”.

17 (3) PROVIDING STATES WITH DATA ON IM-
18 PROPER PAYMENTS MADE FOR ITEMS OR SERVICES
19 PROVIDED TO DUAL ELIGIBLE INDIVIDUALS.—

20 (A) IN GENERAL.—The Secretary shall de-
21 velop and implement a plan that allows each
22 State agency responsible for administering a
23 State plan for medical assistance under title
24 XIX of the Social Security Act access to rel-
25 evant data on improper or fraudulent payments

1 made under the Medicare program under title
 2 XVIII of the Social Security Act (42 U.S.C.
 3 1395 et seq.) for health care items or services
 4 provided to dual eligible individuals.

5 (B) DUAL ELIGIBLE INDIVIDUAL DE-
 6 FINED.—In this paragraph, the term “dual eli-
 7 gible individual” means an individual who is en-
 8 titled to, or enrolled for, benefits under part A
 9 of title XVIII of the Social Security Act (42
 10 U.S.C. 1395c et seq.), or enrolled for benefits
 11 under part B of title XVIII of such Act (42
 12 U.S.C. 1395j et seq.), and is eligible for medical
 13 assistance under a State plan under title XIX
 14 of such Act (42 U.S.C. 1396 et seq.) or under
 15 a waiver of such plan.

16 **TITLE IV—OTHER PROVISIONS**

17 **SEC. 401. COMMISSION ON IMPROVING PATIENT DIRECTED** 18 **HEALTH CARE.**

19 (a) FINDINGS.—Congress finds the following:

20 (1) In order to elevate the role of patient
 21 choices in the health care system, the American pub-
 22 lic must engage in an informed, national, public de-
 23 bate on how the current health care system empow-
 24 ers and informs health care decision-making, and

1 what can be done to improve the likelihood patients
2 receive the care they want and need.

3 (2) Research suggests that patients often do
4 not receive the care they want. As a result, the end
5 of life is associated with a substantial burden of suf-
6 fering by the patient and negative health and finan-
7 cial consequences that extend to family members and
8 society.

9 (3) Patients face a complex and fragmented
10 health care system that may decrease the likelihood
11 that health care choices are known and carried out.
12 The health care system should embed principles that
13 take into account patient wishes.

14 (4) Decisions concerning health care, including
15 end-of-life issues, affect an increasing number of
16 Americans.

17 (5) Medical advances are prolonging life expect-
18 ancy in the United States both in acute life-threat-
19 ening situations and protracted battles with illness.
20 These advances raise new challenges surrounding
21 health care decision-making.

22 (6) The United States health care system
23 should promote consideration of a person's pref-
24 erence in health care decision-making and end-of-life
25 choices.

1 (b) COMMISSION.—The Social Security Act is amend-
2 ed by inserting after section 1150B (42 U.S.C. 1320b-
3 24) the following new section:

4 **“SEC. 1150C. COMMISSION ON IMPROVING PATIENT DI-**
5 **RECTED HEALTH CARE.**

6 “(a) PURPOSES.—The purposes of this section are
7 to—

8 “(1) provide a forum for a nationwide public
9 debate on improving patient self-determination in
10 health care decision-making;

11 “(2) identify strategies that ensure every Amer-
12 ican has the health care they want; and

13 “(3) provide recommendations to Congress that
14 result from the debate.

15 “(b) ESTABLISHMENT.—The Secretary shall estab-
16 lish an entity to be known as the Commission on Improv-
17 ing Patient Directed Health Care (referred to in this sec-
18 tion as the ‘Commission’).

19 “(c) MEMBERSHIP.—

20 “(1) NUMBER AND APPOINTMENT.—The Com-
21 mission shall be composed of 15 members. One
22 member shall be the Secretary. The Comptroller
23 General of the United States shall appoint 14 mem-
24 bers.

1 “(2) QUALIFICATIONS.—The membership of the
2 Commission shall include—

3 “(A) health care consumers impacted by
4 decision-making in advance of a health care cri-
5 sis, such as individuals of advanced age, indi-
6 viduals with chronic, terminal and mental ill-
7 nesses, family care givers, and individuals with
8 disabilities;

9 “(B) providers in settings where crucial
10 health care decision-making occurs, such as
11 those working in intensive care settings, emer-
12 gency room departments, primary care settings,
13 nursing homes, hospice, or palliative care set-
14 tings;

15 “(C) payors ensuring patients get the level
16 of care they want;

17 “(D) experts in advance care planning,
18 hospice, palliative care, information technology,
19 bioethics, aging policy, disability policy, pedi-
20 atric ethics, cultural sensitivity, psychology, and
21 health care financing;

22 “(E) individuals who represent culturally
23 diverse perspectives on patient self-determina-
24 tion and end-of-life issues; and

25 “(F) members of the faith community.

1 “(d) PERIOD OF APPOINTMENT.—Members of the
2 Commission shall be appointed for the life of the Commis-
3 sion. Any vacancies shall not affect the power and duties
4 of the Commission but shall be filled in the same manner
5 as the original appointment.

6 “(e) DESIGNATION OF THE CHAIRPERSON.—Not
7 later than 15 days after the date on which all members
8 of the Commission have been appointed, the Comptroller
9 General shall designate the chairperson of the Commis-
10 sion.

11 “(f) SUBCOMMITTEES.—The Commission may estab-
12 lish subcommittees if doing so increases the efficiency of
13 the Commission in completing tasks.

14 “(g) DUTIES.—

15 “(1) HEARINGS.—Not later than 90 days after
16 the date of designation of the chairperson under
17 subsection (e), the Commission shall hold no fewer
18 than 8 hearings to examine—

19 “(A) the current state of health care deci-
20 sion-making and advance care planning laws in
21 the United States at the Federal level and
22 across the States, as well as options for improv-
23 ing advance care planning tools, especially with
24 regard to use, portability, and storage;

1 “(B) consumer-focused approaches that
2 educate the American public about patient
3 choices, care planning, and other end-of-life
4 issues;

5 “(C) the use of comprehensive, patient-cen-
6 tered care plans by providers, the impact care
7 plans have on health care delivery and spend-
8 ing, and methods to expand the use of high
9 quality care planning tools in both public and
10 private health care systems;

11 “(D) the role of electronic medical records
12 and other technologies in improving patient-di-
13 rected health care;

14 “(E) innovative tools for improving patient
15 experience with advanced illness, such as pallia-
16 tive care, hospice, and other models;

17 “(F) the role social determinants of health,
18 such as socio-economic status, play in patient
19 self-direction in health care;

20 “(G) the use of culturally-competent tools
21 for health care decision-making;

22 “(H) strategies for educating providers
23 and increasing provider engagement on care
24 planning, palliative care, hospice care, and

1 other issues surrounding honoring patient
2 choices;

3 “(I) the sociological and psychological fac-
4 tors that influence health care decision-making
5 and end-of-life choices; and

6 “(J) the role of spirituality and religion in
7 patient self-determination in health care.

8 “(2) ADDITIONAL HEARINGS.—The Commission
9 may hold additional hearings on subjects other than
10 those listed in paragraph (1) so long as such hear-
11 ings are determined necessary by the Commission in
12 carrying out the purposes of this section. Such addi-
13 tional hearings do not have to be completed within
14 the time period specified but shall not delay the
15 other activities of the Commission under this sec-
16 tion.

17 “(3) NUMBER AND LOCATION OF HEARINGS
18 AND ADDITIONAL HEARINGS.—The Commission shall
19 hold no fewer than 8 hearings as indicated in para-
20 graph (1) and in sufficient number in order to re-
21 ceive information that reflects—

22 “(A) the geographic differences throughout
23 the United States;

24 “(B) diverse populations; and

1 “(C) a balance among urban and rural
2 populations.

3 “(4) INTERACTIVE TECHNOLOGY.—The Com-
4 mission may encourage public participation in hear-
5 ings through interactive technology and other means
6 as determined appropriate by the Commission.

7 “(5) REPORT TO THE AMERICAN PEOPLE ON
8 PATIENT DIRECTED HEALTH CARE.—Not later than
9 90 days after the hearings described in paragraphs
10 (1) and (2) are completed, the Commission shall
11 prepare and make available to health care consumers
12 through the Internet and other appropriate public
13 channels, a report to be entitled, ‘Report to the
14 American People on Patient Directed Health Care’.
15 Such a report shall be understandable to the general
16 public and include—

17 “(A) a summary of—

18 “(i) the hearings described in such
19 paragraphs;

20 “(ii) how the current health care sys-
21 tem empowers and informs decision-mak-
22 ing in advance of a health care crisis;

23 “(iii) factors that contribute to the
24 provision of health care that does not ad-
25 here to patient wishes;

1 “(iv) the impact of care that does not
2 follow patient choices, particularly at the
3 end-of-life, on patients, families, providers,
4 spending, and the health care system;

5 “(v) the laws surrounding advance
6 care planning and health care decision-
7 making including issues of portability, use,
8 and storage;

9 “(vi) consumer-focused approaches to
10 education of the American public about pa-
11 tient choices, care planning, and other end-
12 of-life issues;

13 “(vii) the role of care plans in health
14 care decision-making;

15 “(viii) the role of providers in ensur-
16 ing patients receive the care they want;

17 “(ix) the role of electronic medical
18 records and other technologies in improv-
19 ing patient directed health care;

20 “(x) the impact of social determinants
21 on patient self-direction in health care
22 services;

23 “(xi) the use of culturally competent
24 methods for health care decision-making;

1 “(xii) the sociological and psycho-
2 logical factors that influence patient self-
3 determination; and

4 “(xiii) the role of spirituality and reli-
5 gion in health care decision-making and
6 end-of-life care;

7 “(B) best practices from communities, pro-
8 viders, and payors that document patient wish-
9 es and provide health care that adheres to those
10 wishes; and

11 “(C) information on educating providers
12 about health care decision-making and end-of-
13 life issues.

14 “(6) INTERIM REQUIREMENTS.—Not later than
15 180 days after the date of completion of the hear-
16 ings, the Commission shall prepare and make avail-
17 able to the public through the Internet and other ap-
18 propriate public channels, an interim set of rec-
19 ommendations on patient self-determination in
20 health care and ways to improve and strengthen the
21 health care system based on the information and
22 preferences expressed at the community meetings.
23 There shall be a 90-day public comment period on
24 such recommendations.

1 “(h) RECOMMENDATIONS.—Not later than 120 days
2 after the expiration of the public comment period de-
3 scribed in subsection (g)(6), the Commission shall submit
4 to Congress and the President a final set of recommenda-
5 tions. The recommendations must be comprehensive and
6 detailed. The recommendations must contain rec-
7 ommendations or proposals for legislative or administra-
8 tive action as the Commission deems appropriate, includ-
9 ing proposed legislative language to carry out the rec-
10 ommendations or proposals.

11 “(i) ADMINISTRATION.—

12 “(1) EXECUTIVE DIRECTOR.—There shall be an
13 Executive Director of the Commission who shall be
14 appointed by the chairperson of the Commission in
15 consultation with the members of the Commission.

16 “(2) COMPENSATION.—While serving on the
17 business of the Commission (including travel time),
18 a member of the Commission shall be entitled to
19 compensation at the per diem equivalent of the rate
20 provided for level IV of the Executive Schedule
21 under section 5315 of title 5, United States Code,
22 and while so serving away from home and the mem-
23 ber’s regular place of business, a member may be al-
24 lowed travel expenses, as authorized by the chair-
25 person of the Commission. For purposes of pay and

1 employment benefits, rights, and privileges, all per-
2 sonnel of the Commission shall be treated as if they
3 were employees of the Senate.

4 “(3) INFORMATION FROM FEDERAL AGEN-
5 CIES.—The Commission may secure directly from
6 any Federal department or agency such information
7 as the Commission considers necessary to carry out
8 this section. Upon request of the Commission the
9 head of such department or agency shall furnish
10 such information.

11 “(4) POSTAL SERVICES.—The Commission may
12 use the United States mails in the same manner and
13 under the same conditions as other departments and
14 agencies of the Federal Government.

15 “(j) DETAIL.—Not more than 4 Federal Government
16 employees employed by the Department of Labor, 4 Fed-
17 eral Government employees employed by the Social Secu-
18 rity Administration, and 8 Federal Government employees
19 employed by the Department of Health and Human Serv-
20 ices may be detailed to the Commission under this section
21 without further reimbursement. Any detail of an employee
22 shall be without interruption or loss of civil service status
23 or privilege.

24 “(k) TEMPORARY AND INTERMITTENT SERVICES.—
25 The chairperson of the Commission may procure tem-

1 porary and intermittent services under section 3109(b) of
2 title 5, United States Code, at rates for individuals which
3 do not exceed the daily equivalent of the annual rate of
4 basic pay prescribed for level V of the Executive Schedule
5 under section 5316 of such title.

6 “(l) ANNUAL REPORT.—Not later than 1 year after
7 the date of enactment of this Act, and annually thereafter
8 during the existence of the Commission, the Commission
9 shall report to Congress and make public a detailed de-
10 scription of the expenditures of the Commission used to
11 carry out its duties under this section.

12 “(m) SUNSET OF COMMISSION.—The Commission
13 shall terminate on the date that is 3 years after the date
14 on which all the members of the Commission have been
15 appointed under subsection (c)(1) and appropriations are
16 first made available to carry out this section.

17 “(n) ADMINISTRATION REVIEW AND COMMENTS.—
18 Not later than 45 days after receiving the final rec-
19 ommendations of the Commission under subsection (h),
20 the President shall submit a report to Congress which
21 shall contain—

22 “(1) additional views and comments on such
23 recommendations; and

1 “(2) recommendations for such legislation and
2 administrative action as the President considers ap-
3 propriate.

4 “(o) AUTHORIZATION OF APPROPRIATIONS.—

5 “(1) IN GENERAL.—There are authorized to be
6 appropriated to carry out this section, \$3,000,000
7 for each of fiscal years 2014 and 2015.

8 “(2) REPORT TO THE AMERICAN PEOPLE ON
9 PATIENT DIRECTED HEALTH CARE.—There are au-
10 thorized to be appropriated for the preparation and
11 dissemination of the Report to the American People
12 on Patient Directed Health Care described in sub-
13 section (g)(5), \$1,000,000 for the fiscal year in
14 which the report is required to be submitted.”.

15 **SEC. 402. EXPANSION OF THE DEFINITION OF INPATIENT**
16 **HOSPITAL SERVICES FOR CERTAIN CANCER**
17 **HOSPITALS.**

18 Section 1861(b) of the Social Security Act (42 U.S.C.
19 1395x(b)) is amended—

20 (1) in paragraph (3)—

21 (A) by inserting “(A)” after “(3)”;

22 (B) by adding “and” after the semicolon
23 at the end; and

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

1 “(B) subject to the third sentence of this
2 subsection, with respect to a hospital that—

3 “(i) is described in section
4 1886(d)(1)(B)(v); and

5 “(ii) as of the date of the enactment
6 of the Responsible Medicare SGR Repeal
7 and Beneficiary Access Improvement Act
8 of 2014, is located in the same building, or
9 on the same campus, as another hospital
10 (as described in sections 412.22(e) and
11 412.22(f) of title 42, Code of Federal Reg-
12 ulations, as in effect on such date of enact-
13 ment);

14 items and services described in paragraphs (1)
15 and (2) furnished on or after October 1, 2014,
16 by such hospital described in section
17 1886(d)(1)(B)(v) or by others under arrange-
18 ments with them made by the hospital;” and

19 (2) by adding at the end the following new
20 flush sentence:

21 “Paragraph (3)(B) shall only apply to payments with re-
22 spect to the total number of the hospital’s patient days
23 at any satellite of the hospital or such days at another
24 hospital providing services under arrangements to the hos-
25 pital, determined as of the date of the enactment of the

1 Responsible Medicare SGR Repeal and Beneficiary Access
2 Improvement Act of 2014.”.

3 **SEC. 403. QUALITY MEASURES FOR CERTAIN POST-ACUTE**
4 **CARE PROVIDERS RELATING TO NOTICE AND**
5 **TRANSFER OF PATIENT HEALTH INFORMA-**
6 **TION AND PATIENT CARE PREFERENCES.**

7 (a) DEVELOPMENT.—The Secretary of Health and
8 Human Services (in this section referred to as the “Sec-
9 retary”) shall provide for the development of one or more
10 quality measures under title XVIII of the Social Security
11 Act (42 U.S.C. 1395 et seq.) to accurately communicate
12 the existence and provide for the transfer of patient health
13 information and patient care preferences when an indi-
14 vidual transitions from a hospital to return home or move
15 to other post-acute care settings.

16 (b) USE OF MEASURE DEVELOPERS.—The Secretary
17 shall arrange for the development of such measures by ap-
18 propriate measure developers.

19 (c) ENDORSEMENT.—The Secretary shall arrange for
20 such developed measures to be submitted for endorsement
21 to a consensus-based entity as described in section
22 1890(a) of the Social Security Act (42 U.S.C.
23 1395aaa(a)).

24 (d) USE OF MEASURES.—The Secretary shall,
25 through notice and comment rulemaking, use such meas-

1 ures under the quality reporting programs with respect
2 to—

3 (1) inpatient hospitals under section
4 1886(b)(3)(B)(viii) of the Social Security Act (42
5 U.S.C. 1395ww(b)(3)(B)(viii));

6 (2) skilled nursing facilities under section
7 1888(e) of such Act (42 U.S.C. 1395yy(e));

8 (3) home health services under section
9 1895(b)(3)(B)(v) of such Act (42 U.S.C.
10 1395fff(b)(3)(B)(v)); and

11 (4) other providers of services (as defined in
12 section 1861(u) of such Act) and suppliers (as de-
13 fined in section 1861(d) of such Act) that the Sec-
14 retary determines appropriate.

15 **SEC. 404. CRITERIA FOR MEDICALLY NECESSARY, SHORT**
16 **INPATIENT HOSPITAL STAYS.**

17 (a) IN GENERAL.—The Secretary of Health and
18 Human Services shall consult with, and seek input from,
19 interested stakeholders to determine appropriate criteria
20 for payment under the Medicare program under title
21 XVIII of the Social Security Act of an inpatient hospital
22 admission that—

23 (1) is medically necessary; and

24 (2) is an inpatient hospital stay that is less
25 than two midnights, as described in section 412.3 of

1 title 42, Code of Federal Regulation, as finalized in
2 the final rule published by the Centers for Medicare
3 & Medicaid Services in the Federal Register on Au-
4 gust 19, 2013 (78 Federal Register 50496) entitled
5 “Medicare Program; Hospital Inpatient Prospective
6 Payment Systems for Acute Care Hospitals and the
7 Long-Term Care Hospital Prospective Payment Sys-
8 tem and Fiscal Year 2014 Rates; Quality Reporting
9 Requirements for Specific Providers; Hospital Con-
10 ditions of Participation; Payment Policies Related to
11 Patient Status”.

12 (b) INTERESTED STAKEHOLDERS.—In subsection
13 (a), the term “interested stakeholders” means the fol-
14 lowing:

15 (1) Hospitals.

16 (2) Physicians

17 (3) Medicare administrative contractors under
18 section 1874A of the Social Security Act (42 U.S.C.
19 1395kk–1).

20 (4) Recovery audit contractors under section
21 1893(h) of such Act (42 U.S.C. 1395ddd(h)).

22 (5) Other parties determined appropriate by the
23 Secretary.

1 **SEC. 405. TRANSPARENCY OF REASONS FOR EXCLUDING**
2 **ADDITIONAL PROCEDURES FROM THE MEDI-**
3 **CARE AMBULATORY SURGICAL CENTER (ASC)**
4 **APPROVED LIST.**

5 Section 1833(i)(1) of the Social Security Act (42
6 U.S.C. 1395l(i)(1)) is amended by adding at the end the
7 following: “In updating such lists for application in years
8 beginning after December 31, 2014, for each procedure
9 that was not proposed but was requested to be included
10 on such lists during the public comment where the Sec-
11 retary does not finalize (in the final rule updating such
12 lists) to so include, the Secretary shall describe in such
13 final rule the specific safety criteria for not including such
14 requested procedure on such lists.”.

15 **SEC. 406. SUPERVISION IN CRITICAL ACCESS HOSPITALS.**

16 (a) **GENERAL SUPERVISION IN CRITICAL ACCESS**
17 **HOSPITALS.**—Section 1834(g) of the Social Security Act
18 (42 U.S.C. 1395m(g)) is amended by adding at the end
19 the following new paragraph:

20 “(6) **SUPERVISION.**—In the case of services fur-
21 nished on or after the date of the enactment of this
22 paragraph, the minimum level of supervision with re-
23 spect to outpatient therapeutic critical access hos-
24 pital services shall be general supervision (as defined
25 by the Secretary).”.

1 (b) SUPERVISION OF CARDIAC AND PULMONARY RE-
 2 HABILITATION PROGRAMS IN CRITICAL ACCESS HOS-
 3 PITALS.—Section 1861(eee)(2)(B) of the Social Security
 4 Act (42 U.S.C. 1395x(eee)(2)(B)) is amended by inserting
 5 “, or in the case of a critical access hospital, a physician,
 6 or (beginning on the date of enactment of Responsible
 7 Medicare SGR Repeal and Beneficiary Access Improve-
 8 ment Act of 2014) a nurse practitioner, clinical nurse spe-
 9 cialist, or physician assistant (as such terms are defined
 10 in subsection (aa)(5)),” after “a physician”.

11 **SEC. 407. REQUIRING STATE LICENSURE OF BIDDING ENTI-**
 12 **TIES UNDER THE COMPETITIVE ACQUISITION**
 13 **PROGRAM FOR CERTAIN DURABLE MEDICAL**
 14 **EQUIPMENT, PROSTHETICS, ORTHOTICS, AND**
 15 **SUPPLIES (DMEPOS).**

16 Section 1847(a)(1) of the Social Security Act (42
 17 U.S.C. 1395w–3(a)(1)) is amended by adding at the end
 18 the following new subparagraph:

19 “(G) REQUIRING STATE LICENSURE OF
 20 BIDDING ENTITIES.—With respect to rounds of
 21 competitions beginning on or after the date of
 22 enactment of this subparagraph, the Secretary
 23 may only accept a bid from an entity for an
 24 area if the entity meets applicable State licen-

1 sure requirements for such area for all items in
2 such bid for a product category.”.

3 **SEC. 408. RECOGNITION OF ATTENDING PHYSICIAN ASSIST-**
4 **ANTS AS ATTENDING PHYSICIANS TO SERVE**
5 **HOSPICE PATIENTS.**

6 (a) RECOGNITION OF ATTENDING PHYSICIAN AS-
7 SISTANTS AS ATTENDING PHYSICIANS TO SERVE HOS-
8 PICE PATIENTS.—

9 (1) IN GENERAL.—Section 1861(dd)(3)(B) of
10 the Social Security Act (42 U.S.C. 1395x(dd)(3)(B))
11 is amended—

12 (A) by striking “or nurse” and inserting “,
13 the nurse”; and

14 (B) by inserting “, or the physician assist-
15 ant (as defined in such subsection)” after “sub-
16 section (aa)(5))”.

17 (2) CLARIFICATION OF HOSPICE ROLE OF PHY-
18 SICIAN ASSISTANTS.—Section 1814(a)(7)(A)(i)(I) of
19 the Social Security Act (42 U.S.C.
20 1395f(a)(7)(A)(i)(I)) is amended by inserting “or a
21 physician assistant” after “a nurse practitioner”.

22 (b) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to items and services furnished on
24 or after October 1, 2015.

1 **SEC. 409. REMOTE PATIENT MONITORING PILOT**
2 **PROJECTS.**

3 (a) PILOT PROJECTS.—

4 (1) IN GENERAL.—Not later than 9 months
5 after the date of the enactment of this Act, the Sec-
6 retary shall conduct pilot projects under title XVIII
7 of the Social Security Act for the purpose of pro-
8 viding incentives to home health agencies to furnish
9 remote patient monitoring services that reduce ex-
10 penditures under such title.

11 (2) SITE REQUIREMENTS.—

12 (A) URBAN AND RURAL.—The Secretary
13 shall conduct the pilot projects under this sec-
14 tion in both urban and rural areas.

15 (B) SITE IN A SMALL STATE.—The Sec-
16 retary shall conduct at least 1 of the pilot
17 projects in a State with a population of less
18 than 1,000,000.

19 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
20 OF PROJECTS.—

21 (1) IN GENERAL.—The Secretary shall specify
22 the criteria for identifying those Medicare bene-
23 ficiaries who shall be considered within the scope of
24 the pilot projects under this section for purposes of
25 the application of subsection (c) and for the assess-

1 ment of the effectiveness of the home health agency
2 in achieving the objectives of this section.

3 (2) CRITERIA.—The criteria specified under
4 paragraph (1)—

5 (A) shall include conditions and clinical
6 circumstances, including congestive heart fail-
7 ure, diabetes, and chronic pulmonary obstruc-
8 tive disease, and other conditions determined
9 appropriate by the Secretary; and

10 (B) may provide for the inclusion in the
11 projects of Medicare beneficiaries who begin re-
12 ceiving home health services under title XVIII
13 of the Social Security Act after the date of the
14 implementation of the projects.

15 (c) INCENTIVES.—

16 (1) PERFORMANCE TARGETS.—The Secretary
17 shall establish for each home health agency partici-
18 pating in a pilot project under this section a per-
19 formance target using one of the following meth-
20 odologies, as determined appropriate by the Sec-
21 retary:

22 (A) ADJUSTED HISTORICAL PERFORMANCE
23 TARGET.—The Secretary shall establish for the
24 agency—

1 (i) a base expenditure amount equal
2 to the average total payments made under
3 parts A, B, and D of title XVIII of the So-
4 cial Security Act for Medicare beneficiaries
5 determined to be within the scope of the
6 pilot project in a base period determined
7 by the Secretary; and

8 (ii) an annual per capita expenditure
9 target for such beneficiaries, reflecting the
10 base expenditure amount adjusted for risk,
11 changes in costs, and growth rates.

12 (B) COMPARATIVE PERFORMANCE TAR-
13 GET.—The Secretary shall establish for the
14 agency a comparative performance target equal
15 to the average total payments made under such
16 parts A, B, and D during the pilot project for
17 comparable individuals in the same geographic
18 area that are not determined to be within the
19 scope of the pilot project.

20 (2) PAYMENT.—Subject to paragraph (3), the
21 Secretary shall pay to each home health agency par-
22 ticipating in a pilot project a payment for each year
23 under the pilot project equal to a 75 percent share
24 of the total Medicare cost savings realized for such

1 year relative to the performance target under para-
2 graph (1).

3 (3) LIMITATION ON EXPENDITURES.—The Sec-
4 retary shall limit payments under this section in
5 order to ensure that the aggregate expenditures
6 under title XVIII of the Social Security Act (includ-
7 ing payments under this subsection) do not exceed
8 the amount that the Secretary estimates would have
9 been expended if the pilot projects under this section
10 had not been implemented, including any reasonable
11 costs incurred by the Secretary in the administration
12 of the pilot projects.

13 (4) NO DUPLICATION IN PARTICIPATION IN
14 SHARED SAVINGS PROGRAMS.—A home health agen-
15 cy that participates in any of the following shall not
16 be eligible to participate in the pilot projects under
17 this section:

18 (A) A model tested or expanded under sec-
19 tion 1115A of the Social Security Act (42
20 U.S.C. 1315a) that involves shared savings
21 under title XVIII of such Act or any other pro-
22 gram or demonstration project that involves
23 such shared savings.

1 (B) The independence at home medical
2 practice demonstration program under section
3 1866E of such Act (42 U.S.C. 1395cc-5).

4 (d) WAIVER AUTHORITY.—The Secretary may waive
5 such provisions of titles XI and XVIII of the Social Secu-
6 rity Act as the Secretary determines to be appropriate for
7 the conduct of the pilot projects under this section.

8 (e) REPORT TO CONGRESS.—Not later than 3 years
9 after the date that the first pilot project under this section
10 is implemented, the Secretary shall submit to Congress a
11 report on the projects. Such report shall contain—

12 (1) a detailed description of the projects, in-
13 cluding any changes in clinical outcomes for Medi-
14 care beneficiaries under the projects, Medicare bene-
15 ficiary satisfaction under the projects, utilization of
16 items and services under parts A, B, and D of title
17 XVIII of the Social Security Act by Medicare bene-
18 ficiaries under the projects, and Medicare per-bene-
19 ficiary and Medicare aggregate spending under the
20 projects;

21 (2) a detailed description of issues related to
22 the expansion of the projects under subsection (f);

23 (3) recommendations for such legislation and
24 administrative actions as the Secretary considers ap-
25 propriate; and

1 (4) other items considered appropriate by the
2 Secretary.

3 (f) EXPANSION.—If the Secretary determines that
4 any of the pilot projects under this section enhance health
5 outcomes for Medicare beneficiaries and reduce expendi-
6 tures under title XVIII of the Social Security Act, the Sec-
7 retary shall initiate comparable projects in additional
8 areas.

9 (g) PAYMENTS HAVE NO EFFECT ON OTHER MEDI-
10 CARE PAYMENTS TO HOME HEALTH AGENCIES.—A pay-
11 ment under this section shall have no effect on the amount
12 of payments that a home health agency would otherwise
13 receive under title XVIII of the Social Security Act for
14 the provision of home health services.

15 (h) STUDY AND REPORT ON THE APPROPRIATE
16 VALUATION FOR REMOTE PATIENT MONITORING SERV-
17 ICES UNDER THE MEDICARE PHYSICIAN FEE SCHED-
18 ULE.—

19 (1) STUDY.—The Secretary shall conduct a
20 study on the appropriate valuation for remote pa-
21 tient monitoring services under the Medicare physi-
22 cian fee schedule under section 1848 of the Social
23 Security Act (42 U.S.C. 1395w-4) in order to accu-
24 rately reflect the resources involved in furnishing
25 such services.

1 (2) REPORT.—Not later than 6 months after
2 the date of the enactment of this Act, the Secretary
3 shall submit to Congress a report on the study con-
4 ducted under paragraph (1), together with such rec-
5 ommendations as the Secretary determines appro-
6 priate.

7 (i) DEFINITIONS.—In this section:

8 (1) HOME HEALTH AGENCY.—The term “home
9 health agency” has the meaning given that term in
10 section 1861(o) of the Social Security Act (42
11 U.S.C. 1395x(o)).

12 (2) REMOTE PATIENT MONITORING SERV-
13 ICES.—

14 (A) IN GENERAL.—The term “remote pa-
15 tient monitoring services” means services fur-
16 nished in the home using remote patient moni-
17 toring technology which—

18 (i) shall include patient monitoring or
19 patient assessment; and

20 (ii) may include in-home technology-
21 based professional consultations, patient
22 training services, clinical observation,
23 treatment, and any additional services that
24 utilize technologies specified by the Sec-
25 retary.

1 (B) LIMITATION.—The term “remote pa-
2 tient monitoring services” shall not include a
3 telecommunication that consists solely of a tele-
4 phone audio conversation, facsimile, or elec-
5 tronic text mail between a health care profes-
6 sional and a patient.

7 (3) REMOTE PATIENT MONITORING TECH-
8 NOLOGY.—The term “remote patient monitoring
9 technology” means a coordinated system that uses
10 one or more home-based or mobile monitoring de-
11 vices that automatically transmit vital sign data or
12 information on activities of daily living and may in-
13 clude responses to assessment questions collected on
14 the devices wirelessly or through a telecommuni-
15 cations connection to a server that complies with the
16 Federal regulations (concerning the privacy of indi-
17 vidually identifiable health information) promulgated
18 under section 264(c) of the Health Insurance Port-
19 ability and Accountability Act of 1996, as part of an
20 established plan of care for that patient that in-
21 cludes the review and interpretation of that data by
22 a health care professional.

23 (4) SECRETARY.—The term “Secretary” means
24 the Secretary of Health and Human Services.

1 **SEC. 410. COMMUNITY-BASED INSTITUTIONAL SPECIAL**
2 **NEEDS PLAN DEMONSTRATION PROGRAM.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services (referred to in this section as the “Sec-
5 retary”) shall establish a Community-Based Institutional
6 Special Needs Plan (CBI-SNP) demonstration program to
7 prevent and delay institutionalization under Medicaid
8 among targeted low-income Medicare beneficiaries.

9 (b) ESTABLISHMENT.—The Secretary shall enter into
10 agreements with not more than 5 specialized MA plans
11 for special needs individuals, as defined in section
12 1859(b)(6)(B)(i) of the Social Security Act (42 U.S.C.
13 1395w–28(b)(6)(B)(i)), to conduct the CBI-SNP dem-
14 onstration program. Under the CBI-SNP demonstration
15 program, a targeted low-income Medicare beneficiary shall
16 receive, as supplemental benefits under section 1852(a)(3)
17 of such Act (42 U.S.C. 1395w-22(a)(3)), long-term care
18 services or supports that—

19 (1) the Secretary determines appropriate for
20 the purposes of the CBI-SNP demonstration pro-
21 gram; and

22 (2) for which payment may be made under the
23 State plan under title XIX of such Act (42 U.S.C.
24 1396 et seq.) of the State in which the targeted low-
25 income Medicare beneficiary is located.

1 (c) ELIGIBLE PLANS.—To be eligible to participate
2 in the CBI-SNP demonstration program, a specialized MA
3 plan for special needs individuals must—

4 (1) serve special needs individuals (as defined
5 in section 1859(b)(6)(B)(i) of the Social Security
6 Act (42 U.S.C. 1395w–28(b)(6)(B)(i));

7 (2) have experience in offering special needs
8 plans for nursing home-eligible, non-institutionalized
9 Medicare beneficiaries who live in the community;

10 (3) be located in a State that the Secretary has
11 determined will participate in the CBI-SNP dem-
12 onstration program by agreeing to make available
13 data necessary for purposes of conducting the inde-
14 pendent evaluation required under subsection (f);
15 and

16 (4) meet such other criteria as the Secretary
17 may require.

18 (d) TARGETED LOW-INCOME MEDICARE BENE-
19 FICIARY DEFINED.—In this section, the term “targeted
20 low-income Medicare beneficiary” means a Medicare bene-
21 ficiary who—

22 (1) is enrolled in a specialized MA plan for spe-
23 cial needs individuals that has been selected to par-
24 ticipate in the CBI-SNP demonstration program;

1 (2) is a subsidy eligible individual (as defined in
2 section 1860D–14(a)(3)(A) of the Social Security
3 Act (42 U.S.C. 1395w-114(a)(3)(A)); and

4 (3) is unable to perform 2 or more activities of
5 daily living (as defined in section 7702B(e)(2)(B) of
6 the Internal Revenue Code of 1986).

7 (e) IMPLEMENTATION DEADLINE; DURATION.—The
8 CBI-SNP demonstration program shall be implemented
9 not later than January 1, 2016, and shall be conducted
10 for a period of 3 years.

11 (f) INDEPENDENT EVALUATION AND REPORTS.—

12 (1) INDEPENDENT EVALUATION.—Not later
13 than 2 years after the completion of the CBI-SNP
14 demonstration program, the Secretary shall provide
15 for the evaluation of the CBI-SNP demonstration
16 program by an independent third party. The evalua-
17 tion shall determine whether the CBI-SNP dem-
18 onstration program has improved patient care and
19 quality of life for the targeted low-income Medicare
20 beneficiaries participating in the CBI-SNP dem-
21 onstration program. Specifically, the evaluation shall
22 determine if the CBI-SNP demonstration program
23 has—

24 (A) reduced hospitalizations or re-hos-
25 pitalizations;

1 (B) reduced Medicaid nursing home facility
2 stays; and

3 (C) reduced spenddown of income and as-
4 sets for purposes of becoming eligible for Med-
5 icaid.

6 (2) REPORTS.—Not later than 3 years after the
7 completion of the CBI-SNP demonstration program,
8 the Secretary shall submit to Congress a report con-
9 taining the results of the evaluation conducted under
10 paragraph (1), together with such recommendations
11 for legislative or administrative action as the Sec-
12 retary determines appropriate.

13 (g) FUNDING.—

14 (1) FUNDING FOR IMPLEMENTATION.—For
15 purposes of carrying out the demonstration program
16 under this section (other than the evaluation and re-
17 port under subsection (f)), the Secretary shall pro-
18 vide for the transfer from the Federal Hospital In-
19 surance Trust Fund under section 1817 of the So-
20 cial Security Act (42 U.S.C. 1395i) and the Federal
21 Supplementary Medical Insurance Trust Fund under
22 section 1841 of such Act (42 U.S.C. 1395t), in such
23 proportion as the Secretary determines appropriate,
24 of \$3,000,000 to the Centers for Medicare & Med-
25 icaid Services Program Management Account.

1 (2) FUNDING FOR EVALUATION AND REPORT.—

2 For purposes of carrying out the evaluation and re-
3 port under subsection (f), the Secretary shall provide
4 for the transfer from the Federal Hospital Insurance
5 Trust Fund under such section 1817 and the Fed-
6 eral Supplementary Medical Insurance Trust Fund
7 under such section 1841, in such proportion as the
8 Secretary determines appropriate, of \$500,000.

9 (3) AVAILABILITY.—Amounts transferred under
10 paragraph (1) or (2) shall remain available until ex-
11 pended.

12 (h) BUDGET NEUTRALITY.—In conducting the CBI-
13 SNP demonstration program, the Secretary shall ensure
14 that the aggregate payments made by the Secretary do
15 not exceed the amount which the Secretary estimates
16 would have been expended under titles XVIII and XIX
17 of the Social Security Act (42 U.S.C. 1395 et seq., 1396
18 et seq.) if the CBI-SNP demonstration program had not
19 been implemented.

20 (i) PAPERWORK REDUCTION ACT.—Chapter 35 of
21 title 44, United States Code, shall not apply to the testing
22 and evaluation of the CBI-SNP demonstration program
23 under this section.

1 **SEC. 411. APPLYING CMMI WAIVER AUTHORITY TO PACE IN**
2 **ORDER TO FOSTER INNOVATIONS.**

3 (a) CMMI WAIVER AUTHORITY.—Subsection (d)(1)
4 of section 1115A of the Social Security Act (42 U.S.C.
5 1315a) is amended—

6 (1) by inserting “(other than subsections
7 (b)(1)(A) and (c)(5) of section 1894)” after
8 “XVIII”; and

9 (2) by striking “and 1903(m)(2)(A)(iii)” and
10 inserting “1903(m)(2)(A)(iii), and 1934 (other than
11 subsections (b)(1)(A) and (c)(5) of such section)”.

12 (b) SENSE OF THE SENATE.—It is the sense of the
13 Senate that the Secretary of Health and Human Services
14 should use the waiver authority provided under the
15 amendments made by this section to provide, in a budget
16 neutral manner, programs of all-inclusive care for the el-
17 derly (PACE programs) with increased operational flexi-
18 bility to support the ability of such programs to improve
19 and innovate and to reduce technical and administrative
20 barriers that have hindered enrollment in such programs.

21 **SEC. 412. IMPROVE AND MODERNIZE MEDICAID DATA SYS-**
22 **TEMS AND REPORTING.**

23 (a) IN GENERAL.—The Secretary of Health and
24 Human Services shall implement a strategic plan to in-
25 crease the usefulness of data about State Medicaid pro-
26 grams reported by States to the Centers for Medicare &

1 Medicaid Services. The strategic plan shall address
2 redundancies and gaps in Medicaid data systems and re-
3 porting through improvements to, and modernization of,
4 computer and data systems. Areas for improvement under
5 the plan shall include (but not be limited to) the following:

6 (1) The reporting of encounter data by man-
7 aged care plans.

8 (2) The timeliness and quality of reported data,
9 including enrollment data.

10 (3) The consistency of data reported from mul-
11 tiple sources.

12 (4) Information about State program policies.

13 (b) IMPLEMENTATION STATUS REPORT.—Not later
14 than 1 year after the date of enactment of this Act, the
15 Secretary of Health and Human Services shall submit a
16 report to Congress on the status of the implementation
17 of the strategic plan required under subsection (a).

18 (c) AUTHORIZATION OF APPROPRIATIONS.—There is
19 authorized to be appropriated to the Secretary of Health
20 and Human Services for the period of fiscal years 2015
21 through 2019, such sums as may be necessary to carry
22 out this section.

1 **SEC. 413. FAIRNESS IN MEDICAID SUPPLEMENTAL NEEDS**
 2 **TRUSTS.**

3 (a) **IN GENERAL.**—Section 1917(d)(4)(A) of the So-
 4 cial Security Act (42 U.S.C. 1396p(d)(4)(A)) is amended
 5 by inserting “the individual,” after “for the benefit of such
 6 individual by”.

7 (b) **EFFECTIVE DATE.**—The amendment made by
 8 subsection (a) shall apply to trusts established on or after
 9 the date of the enactment of this Act.

10 **SEC. 414. HELPING ENSURE LIFE- AND LIMB-SAVING AC-**
 11 **CESS TO PODIATRIC PHYSICIANS.**

12 (a) **INCLUDING PODIATRISTS AS PHYSICIANS UNDER**
 13 **THE MEDICAID PROGRAM.**—

14 (1) **IN GENERAL.**—Section 1905(a)(5)(A) of the
 15 Social Security Act (42 U.S.C. 1396d(a)(5)(A)) is
 16 amended by striking “section 1861(r)(1)” and in-
 17 serting “paragraphs (1) and (3) of section 1861(r)”.

18 (2) **EFFECTIVE DATE.**—

19 (A) **IN GENERAL.**—Except as provided in
 20 subparagraph (B), the amendment made by
 21 paragraph (1) shall apply to services furnished
 22 on or after the date of enactment of this Act.

23 (B) **EXTENSION OF EFFECTIVE DATE FOR**
 24 **STATE LAW AMENDMENT.**—In the case of a
 25 State plan under title XIX of the Social Secu-
 26 rity Act (42 U.S.C. 1396 et seq.) which the

1 Secretary of Health and Human Services deter-
2 mines requires State legislation in order for the
3 plan to meet the additional requirement im-
4 posed by the amendment made by paragraph
5 (1), the State plan shall not be regarded as fail-
6 ing to comply with the requirements of such
7 title solely on the basis of its failure to meet
8 these additional requirements before the first
9 day of the first calendar quarter beginning after
10 the close of the first regular session of the
11 State legislature that begins after the date of
12 enactment of this Act. For purposes of the pre-
13 vious sentence, in the case of a State that has
14 a 2-year legislative session, each year of the ses-
15 sion is considered to be a separate regular ses-
16 sion of the State legislature.

17 (b) MODIFICATIONS TO REQUIREMENTS FOR DIA-
18 BETIC SHOES TO BE INCLUDED UNDER MEDICAL AND
19 OTHER HEALTH SERVICES UNDER MEDICARE.—

20 (1) IN GENERAL.—Section 1861(s)(12) of the
21 Social Security Act (42 U.S.C. 1395x(s)(12)) is
22 amended to read as follows:

23 “(12) subject to section 4072(e) of the Omni-
24 bus Budget Reconciliation Act of 1987, extra-depth
25 shoes with inserts or custom molded shoes (in this

1 paragraph referred to as ‘therapeutic shoes’) with
2 inserts for an individual with diabetes, if—

3 “(A) the physician who is managing the in-
4 dividual’s diabetic condition—

5 “(i) documents that the individual has
6 diabetes;

7 “(ii) certifies that the individual is
8 under a comprehensive plan of care related
9 to the individual’s diabetic condition; and

10 “(iii) documents agreement with the
11 prescribing podiatrist or other qualified
12 physician (as established by the Secretary)
13 that it is medically necessary for the indi-
14 vidual to have such extra-depth shoes with
15 inserts or custom molded shoes with in-
16 serts;

17 “(B) the therapeutic shoes are prescribed
18 by a podiatrist or other qualified physician (as
19 established by the Secretary) who—

20 “(i) examines the individual and de-
21 termines the medical necessity for the indi-
22 vidual to receive the therapeutic shoes; and

23 “(ii) communicates in writing the
24 medical necessity to the physician de-
25 scribed in subparagraph (A) for the indi-

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. 415. DEMONSTRATION PROGRAMS TO IMPROVE COM-**
 19 **MUNITY MENTAL HEALTH SERVICES.**

20 (a) CRITERIA FOR CERTIFIED COMMUNITY BEHAV-
 21 IORAL HEALTH CLINICS TO PARTICIPATE IN DEM-
 22 ONSTRATION PROGRAMS.—

23 (1) PUBLICATION.—Not later than September
 24 1, 2015, the Secretary shall publish criteria for a
 25 clinic to be certified by a State as a certified com-

1 community behavioral health clinic for purposes of par-
2 ticipating in a demonstration program conducted
3 under subsection (d).

4 (2) REQUIREMENTS.—The criteria published
5 under this subsection shall include criteria with re-
6 spect to the following:

7 (A) STAFFING.—Staffing requirements, in-
8 cluding criteria that staff have diverse discipli-
9 nary backgrounds, have necessary State-re-
10 quired license and accreditation, and are cul-
11 turally and linguistically trained to serve the
12 needs of the clinic’s patient population.

13 (B) AVAILABILITY AND ACCESSIBILITY OF
14 SERVICES.—Availability and accessibility of
15 services, including crisis management services
16 that are available and accessible 24 hours a
17 day, the use of a sliding scale for payment, and
18 no rejection for services or limiting of services
19 on the basis of a patient’s ability to pay or a
20 place of residence.

21 (C) CARE COORDINATION.—Care coordina-
22 tion, including requirements to coordinate care
23 across settings and providers to ensure seamless
24 transitions for patients across the full spectrum
25 of health services including acute, chronic, and

1 behavioral health needs. Care coordination re-
2 quirements shall include partnerships or formal
3 contracts with the following:

4 (i) Federally-qualified health centers
5 (and as applicable, rural health clinics) to
6 provide Federally-qualified health center
7 services (and as applicable, rural health
8 clinic services) to the extent such services
9 are not provided directly through the cer-
10 tified community behavioral health clinic.

11 (ii) Inpatient psychiatric facilities and
12 substance use detoxification, post-detoxi-
13 fication step-down services, and residential
14 programs.

15 (iii) Other community or regional
16 services, supports, and providers, including
17 schools, child welfare agencies, juvenile and
18 criminal justice agencies and facilities, In-
19 dian Health Service youth regional treat-
20 ment centers, State licensed and nationally
21 accredited child placing agencies for thera-
22 peutic foster care service, and other social
23 and human services.

24 (iv) Department of Veterans Affairs
25 medical centers, independent outpatient

1 clinics, drop-in centers, and other facilities
2 of the Department as defined in section
3 1801 of title 38, United States Code.

4 (v) Inpatient acute care hospitals and
5 hospital outpatient clinics.

6 (D) SCOPE OF SERVICES.—Provision (in a
7 manner reflecting person-centered care) of the
8 following services which, if not available directly
9 through the certified community behavioral
10 health clinic, are provided or referred through
11 formal relationships with other providers:

12 (i) Crisis mental health services, in-
13 cluding 24-hour mobile crisis teams, emer-
14 gency crisis intervention services, and cri-
15 sis stabilization.

16 (ii) Screening, assessment, and diag-
17 nosis, including risk assessment.

18 (iii) Patient-centered treatment plan-
19 ning or similar processes, including risk as-
20 sessment and crisis planning.

21 (iv) Outpatient mental health and
22 substance use services.

23 (v) Outpatient clinic primary care
24 screening and monitoring of key health in-
25 dicators and health risk.

1 (vi) Targeted case management.

2 (vii) Psychiatric rehabilitation serv-
3 ices.

4 (viii) Peer support and counselor serv-
5 ices and family supports.

6 (ix) Intensive, community-based men-
7 tal health care for members of the armed
8 forces and veterans, particularly those
9 members and veterans located in rural
10 areas, provided the care is consistent with
11 minimum clinical mental health guidelines
12 promulgated by the Veterans Health Ad-
13 ministration including clinical guidelines
14 contained in the Uniform Mental Health
15 Services Handbook of such Administration.

16 (E) QUALITY AND OTHER REPORTING.—
17 Reporting of encounter data, clinical outcomes
18 data, quality data, and such other data as the
19 Secretary requires.

20 (F) ORGANIZATIONAL AUTHORITY.—Cri-
21 teria that a clinic be a non-profit or part of a
22 local government behavioral health authority or
23 operated under the authority of the Indian
24 Health Service, an Indian tribe or tribal organi-
25 zation pursuant to a contract, grant, coopera-

1 tive agreement, or compact with the Indian
2 Health Service pursuant to the Indian Self-De-
3 termination Act (25 U.S.C. 450 et seq.), or an
4 urban Indian organization pursuant to a grant
5 or contract with the Indian Health Service
6 under title V of the Indian Health Care Im-
7 provement Act (25 U.S.C. 1601 et seq.).

8 (b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE
9 PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRA-
10 TION PROGRAMS.—

11 (1) IN GENERAL.—Not later than September 1,
12 2015, the Secretary, through the Administrator of
13 the Centers for Medicare & Medicaid Services, shall
14 issue guidance for the establishment of a prospective
15 payment system that shall only apply to medical as-
16 sistance for mental health services furnished by a
17 certified community behavioral health clinic partici-
18 pating in a demonstration program under subsection
19 (d).

20 (2) REQUIREMENTS.—The guidance issued by
21 the Secretary under paragraph (1) shall provide
22 that—

23 (A) no payment shall be made for inpatient
24 care, residential treatment, room and board ex-

1 penses, or any other non-ambulatory services,
2 as determined by the Secretary; and

3 (B) no payment shall be made to satellite
4 facilities of certified community behavioral
5 health clinics if such facilities are established
6 after the date of enactment of this Act.

7 (c) PLANNING GRANTS.—

8 (1) IN GENERAL.—Not later than January 1,
9 2016, the Secretary shall award planning grants to
10 States for the purpose of developing proposals to
11 participate in time-limited demonstration programs
12 described in subsection (d).

13 (2) USE OF FUNDS.—A State awarded a plan-
14 ning grant under this subsection shall—

15 (A) solicit input with respect to the devel-
16 opment of such a demonstration program from
17 patients, providers, and other stakeholders;

18 (B) certify clinics as certified community
19 behavioral health clinics for purposes of partici-
20 pating in a demonstration program conducted
21 under subsection (d); and

22 (C) establish a prospective payment system
23 for mental health services furnished by a cer-
24 tified community behavioral health clinic par-
25 ticipating in a demonstration program under

1 subsection (d) in accordance with the guidance
2 issued under subsection (b).

3 (d) DEMONSTRATION PROGRAMS.—

4 (1) IN GENERAL.—Not later than September 1,
5 2017, the Secretary shall select States to participate
6 in demonstration programs that are developed
7 through planning grants awarded under subsection
8 (c), meet the requirements of this subsection, and
9 represent a diverse selection of geographic areas, in-
10 cluding rural and underserved areas.

11 (2) APPLICATION REQUIREMENTS.—

12 (A) IN GENERAL.—The Secretary shall so-
13 licit applications to participate in demonstration
14 programs under this subsection solely from
15 States awarded planning grants under sub-
16 section (c).

17 (B) REQUIRED INFORMATION.—An appli-
18 cation for a demonstration program under this
19 subsection shall include the following:

20 (i) The target Medicaid population to
21 be served under the demonstration pro-
22 gram.

23 (ii) A list of participating certified
24 community behavioral health clinics.

1 (iii) Verification that the State has
2 certified a participating clinic as a certified
3 community behavioral health clinic in ac-
4 cordance with the requirements of sub-
5 section (b).

6 (iv) A description of the scope of the
7 mental health services available under the
8 State Medicaid program that will be paid
9 for under the prospective payment system
10 tested in the demonstration program.

11 (v) Verification that the State has
12 agreed to pay for such services at the rate
13 established under the prospective payment
14 system.

15 (vi) Such other information as the
16 Secretary may require relating to the dem-
17 onstration program including with respect
18 to determining the soundness of the pro-
19 posed prospective payment system.

20 (3) NUMBER AND LENGTH OF DEMONSTRATION
21 PROGRAMS.—Not more than 8 States shall be se-
22 lected for 4-year demonstration programs under this
23 subsection.

24 (4) REQUIREMENTS FOR SELECTING DEM-
25 ONSTRATION PROGRAMS.—

1 (A) IN GENERAL.—The Secretary shall
2 give preference to selecting demonstration pro-
3 grams where participating certified community
4 behavioral health clinics—

5 (i) provide the most complete scope of
6 services described in subsection (a)(2)(D)
7 to individuals eligible for medical assist-
8 ance under the State Medicaid program;

9 (ii) will improve availability of, access
10 to, and participation in, services described
11 in subsection (a)(2)(D) to individuals eligi-
12 ble for medical assistance under the State
13 Medicaid program;

14 (iii) will improve availability of, access
15 to, and participation in assisted outpatient
16 mental health treatment in the State; or

17 (iv) demonstrate the potential to ex-
18 pand available mental health services in a
19 demonstration area and increase the qual-
20 ity of such services without increasing net
21 Federal spending.

22 (5) PAYMENT FOR MEDICAL ASSISTANCE FOR
23 MENTAL HEALTH SERVICES PROVIDED BY CER-
24 TIFIED COMMUNITY BEHAVIORAL HEALTH CLIN-
25 ICS.—

1 (A) IN GENERAL.—The Secretary shall pay
2 a State participating in a demonstration pro-
3 gram under this subsection the Federal match-
4 ing percentage specified in subparagraph (B)
5 for amounts expended by the State to provide
6 medical assistance for mental health services
7 described in the demonstration program appli-
8 cation in accordance with paragraph (2)(B)(iv)
9 that are provided by certified community behav-
10 ioral health clinics to individuals who are en-
11 rolled in the State Medicaid program. Payments
12 to States made under this paragraph shall be
13 considered to have been under, and are subject
14 to the requirements of, section 1903 of the So-
15 cial Security Act (42 U.S.C. 1396b).

16 (B) FEDERAL MATCHING PERCENTAGE.—
17 The Federal matching percentage specified in
18 this subparagraph is with respect to medical as-
19 sistance described in subparagraph (A) that is
20 furnished—

21 (i) to a newly eligible individual de-
22 scribed in paragraph (2) of section 1905(y)
23 of the Social Security Act (42 U.S.C.
24 1396d(y)), the matching rate applicable
25 under paragraph (1) of that section; and

1 (ii) to an individual who is not a
2 newly eligible individual (as so described)
3 but who is eligible for medical assistance
4 under the State Medicaid program, the en-
5 hanced FMAP applicable to the State.

6 (C) LIMITATIONS.—

7 (i) IN GENERAL.—Payments shall be
8 made under this paragraph to a State only
9 for mental health services—

10 (I) that are described in the dem-
11 onstration program application in ac-
12 cordance with paragraph (2)(B)(iv);

13 (II) for which payment is avail-
14 able under the State Medicaid pro-
15 gram; and

16 (III) that are provided to an indi-
17 vidual who is eligible for medical as-
18 sistance under the State Medicaid
19 program.

20 (ii) PROHIBITED PAYMENTS.—No
21 payment shall be made under this para-
22 graph—

23 (I) for inpatient care, residential
24 treatment, room and board expenses,

1 or any other non-ambulatory services,
2 as determined by the Secretary; or

3 (II) with respect to payments
4 made to satellite facilities of certified
5 community behavioral health clinics if
6 such facilities are established after the
7 date of enactment of this Act.

8 (6) WAIVER OF STATEWIDENESS REQUIRE-
9 MENT.—The Secretary shall waive section
10 1902(a)(1) of the Social Security Act (42 U.S.C.
11 1396a(a)(1)) (relating to statewideness) as may be
12 necessary to conduct demonstration programs in ac-
13 cordance with the requirements of this subsection.

14 (7) ANNUAL REPORTS.—

15 (A) IN GENERAL.—Not later than 1 year
16 after the date on which the first State is se-
17 lected for a demonstration program under this
18 subsection, and annually thereafter, the Sec-
19 retary shall submit to Congress an annual re-
20 port on the use of funds provided under all
21 demonstration programs conducted under this
22 subsection. Each such report shall include—

23 (i) an assessment of access to commu-
24 nity-based mental health services under the
25 Medicaid program in the area or areas of

1 a State targeted by a demonstration pro-
2 gram compared to other areas of the State;

3 (ii) an assessment of the quality and
4 scope of services provided by certified com-
5 munity behavioral health clinics compared
6 to community-based mental health services
7 provided in States not participating in a
8 demonstration program under this sub-
9 section and in areas of a demonstration
10 State that are not participating in the
11 demonstration program; and

12 (iii) an assessment of the impact of
13 the demonstration programs on the Fed-
14 eral and State costs of a full range of men-
15 tal health services (including inpatient,
16 emergency and ambulatory services).

17 (B) RECOMMENDATIONS.—Not later than
18 December 31, 2021, the Secretary shall submit
19 to Congress recommendations concerning
20 whether the demonstration programs under this
21 section should be continued, expanded, modi-
22 fied, or terminated.

23 (e) DEFINITIONS.—In this section:

24 (1) FEDERALLY-QUALIFIED HEALTH CENTER
25 SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER;

1 RURAL HEALTH CLINIC SERVICES; RURAL HEALTH
2 CLINIC.—The terms “Federally-qualified health cen-
3 ter services”, “Federally-qualified health center”,
4 “rural health clinic services”, and “rural health clin-
5 ic” have the meanings given those terms in section
6 1905(l) of the Social Security Act (42 U.S.C.
7 1396d(l)).

8 (2) ENHANCED FMAP.—The term “enhanced
9 FMAP” has the meaning given that term in section
10 2105(b) of the Social Security Act (42 U.S.C.
11 1397dd(b) but without regard to the second and
12 third sentences of that section.

13 (3) SECRETARY.—The term “Secretary” means
14 the Secretary of Health and Human Services.

15 (4) STATE.—The term “State” has the mean-
16 ing given such term for purposes of title XIX of the
17 Social Security Act (42 U.S.C. 1396 et seq.).

18 (f) FUNDING.—

19 (1) IN GENERAL.—Out of any funds in the
20 Treasury not otherwise appropriated, there is appro-
21 priated to the Secretary—

22 (A) for purposes of carrying out sub-
23 sections (a), (b), and (d)(7), \$2,000,000 for fis-
24 cal year 2014; and

1 (B) for purposes of awarding planning
2 grants under subsection (c), \$25,000,000 for
3 fiscal year 2016.

4 (2) AVAILABILITY.—Funds appropriated under
5 paragraph (1) shall remain available until expended.

6 **SEC. 416. ANNUAL MEDICAID DSH REPORT.**

7 Section 1923 of the Social Security Act (42 U.S.C.
8 1396r-4) is amended by adding at the end the following:

9 “(k) ANNUAL REPORT TO CONGRESS.—

10 “(1) IN GENERAL.—Beginning January 1,
11 2015, and annually thereafter, the Secretary shall
12 submit a report to Congress on the program estab-
13 lished under this section for making payment adjust-
14 ments to disproportionate share hospitals for the
15 purpose of providing Congress with information rel-
16 evant to determining an appropriate level of overall
17 funding for such payment adjustments during and
18 after the period in which aggregate reductions in the
19 DSH allotments to States are required under para-
20 graphs (7) and (8) of subsection (f).

21 “(2) REQUIRED REPORT INFORMATION.—Ex-
22 cept as otherwise provided, each report submitted
23 under this subsection shall include the following:

24 “(A) Information and data relating to
25 changes in the number of uninsured individuals

1 for the most recent year for which such data
2 are available as compared to 2013 and as com-
3 pared to the Congressional Budget Office esti-
4 mates of uninsured individuals made at the
5 time of the enactment of the Patient Protection
6 and Affordable Care Act (Public Law 111–148)
7 and the Health Care and Education Reconcili-
8 ation Act of 2010 (Public Law 111–152).

9 “(B) Information and data relating to the
10 extent to which hospitals continue to incur un-
11 compensated care costs from providing unreim-
12 bursed or under-reimbursed services to individ-
13 uals who either are eligible for medical assist-
14 ance under the State plan under this title or
15 under a waiver of such plan or who have no
16 health insurance (or other source of third party
17 coverage) for such services.

18 “(C) Information and data relating to the
19 extent to which hospitals continue to provide
20 charity care and unreimbursed or under-reim-
21 bursed services, or otherwise incur bad debt,
22 under the program established under this title,
23 the State Children’s Health Insurance Program
24 established under title XXI, and State or local
25 indigent care programs, as reported on cost re-

1 ports submitted under title XVIII or such other
2 data as the Secretary determines appropriate.

3 “(D) In the first report submitted under
4 this section, a methodology for estimating the
5 amount of unpaid patient deductibles, copay-
6 ments and coinsurance incurred by hospitals for
7 patients enrolled in qualified health plans
8 through an American Health Benefits Ex-
9 change, using existing data and minimizing the
10 administrative burden on hospitals to the extent
11 possible, and in subsequent reports, data re-
12 garding such uncompensated care costs col-
13 lected pursuant to such methodology.

14 “(E) For each State, information and data
15 relating to the difference between the DSH al-
16 lotment for the State for the fiscal year that
17 began on October 1 of the year preceding the
18 year in which the report is submitted and the
19 aggregate amount of uncompensated care costs
20 for all disproportionate share hospitals in the
21 State.

22 “(F) Information and data relating to the
23 extent to which there are certain vital hospital
24 systems that are disproportionately experiencing
25 high levels of uncompensated care and that

1 have multiple other missions, such as a commit-
2 ment to graduate medical education, the provi-
3 sion of tertiary and trauma care services, pro-
4 viding public health and essential community
5 services, and providing comprehensive, coordi-
6 nated care.

7 “(G) Such other information and data rel-
8 evant to the determination of the level of fund-
9 ing for, and amount of, State DSH allotments
10 as the Secretary determines appropriate

11 “(3) AUTHORIZATION OF APPROPRIATIONS.—
12 There is authorized to be appropriated to the Sec-
13 retary for the period of fiscal years 2015 through
14 2109, such sums as may be necessary to carry out
15 this subsection.”.

16 **SEC. 417. IMPLEMENTATION.**

17 To the extent the Secretary of Health and Human
18 Services issues a regulation to carry out the provisions of
19 this Act, the Secretary shall, unless otherwise specified in
20 this Act—

21 (1) issue a notice of proposed rulemaking that
22 includes the proposed regulation;

23 (2) provide a period of not less than 60 cal-
24 endar days for comments on the proposed regula-
25 tion;

1 (3) not more than 24 months following the date
2 of publication of the proposed rule, publish the final
3 regulation or take alternative action (such as with-
4 drawing the rule or proposing a revised rule with a
5 new comment period) on the proposed regulation;
6 and

7 (4) not less than 30 days before the effective
8 date of the final regulation, publish the final regula-
9 tion or take alternative action (such as withdrawing
10 the rule or proposing a revised rule with a new com-
11 ment period) on the proposed regulation.

12 **TITLE V—RESTORING**
13 **INDIVIDUAL LIBERTY**

14 **SEC. 501. RESTORING INDIVIDUAL LIBERTY.**

15 Sections 1501 and 1502 and subsections (a), (b), (c),
16 and (d) of section 10106 of the Patient Protection and
17 Affordable Care Act (and the amendments made by such
18 sections and subsections) are repealed and the Internal
19 Revenue Code of 1986 shall be applied and administered
20 as if such provisions and amendments had never been en-
21 acted.

Calendar No. 330

113TH CONGRESS
2^D SESSION

S. 2122

A BILL

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

MARCH 13, 2014

Read the second time and placed on the calendar