To amend title XVIII of the Social Security Act to provide for patient improvements and rural and quality improvements under the Medicare program.

IN THE HOUSE OF REPRESENTATIVES

JUNE 21, 2019

Mr. Neal (for himself and Mr. Brady) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

A BILL

To amend title XVIII of the Social Security Act to provide for patient improvements and rural and quality improvements under the Medicare program.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Beneficiary Education Tools, Telehealth, and Extenders Reauthorization Act of 2019” or the “BETTER Act of 2019”.

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Table of Contents.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

Title I—Patient Improvements

Sec. 101. Beneficiary enrollment notification and eligibility simplification.
Sec. 102. Extension of funding outreach and assistance for low-income programs.
Sec. 103. Medicare coverage of certain mental health telehealth services.
Sec. 104. Requiring prescription drug plan sponsors to include real-time benefit information as part of such sponsor’s electronic prescription program under the Medicare program.
Sec. 105. Transitional coverage and retroactive Medicare Part D coverage for certain low-income beneficiaries.

Title II—Rural and Quality Improvements

Sec. 201. Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations.
Sec. 202. Extension of the work geographic index floor under the Medicare program.
Sec. 203. Extension of funding for quality measure endorsement, input, and selection under Medicare program.
Sec. 204. Improving measurements under the skilled nursing facility value-based purchasing program under the Medicare program.

Title I—Patient Improvements

Sec. 101. Beneficiary Enrollment Notification and Eligibility Simplification.

(a) Eligibility and Enrollment Notices.—

(1) As part of Social Security Account Statement for Individuals Attaining Ages 63 to 65.—Section 1143(a) of the Social Security Act (42 U.S.C. 1320b–13(a)) is amended by adding at the end the following new paragraph:

“(4) Medicare Eligibility Information.—
“(A) IN GENERAL.—In the case of statements provided on or after the date that is 2 years after the date of the enactment of this paragraph to individuals who are attaining ages 63, 64, and 65, the statement shall also include a notice containing the information described in subparagraph (B).

“(B) CONTENTS OF NOTICE.—The notice required under subparagraph (A) shall include a clear, simple explanation of—

“(i) eligibility for benefits under the Medicare program under title XVIII, and in particular benefits under part B of such title;

“(ii) the reasons a late enrollment penalty for failure to timely enroll could be assessed and how such late enrollment penalty is calculated, in particular for benefits under part B;

“(iii) the availability of relief from the late enrollment penalty and retroactive enrollment under section 1837(h) (including as such section is applied under sections 1818(c) and 1818A(e)(3)), with examples of circumstances under which such relief may be granted and examples of circumstances under which such relief would not be granted;
“(iv) the need for coordination of benefits (including primary and secondary coverage scenarios) pursuant to section 1862, in particular for benefits under part B of such title; and

“(v) populations, such as residents of Puerto Rico and veterans, for whom there are special considerations with respect to enrollment under title XVIII.

“(C) DEVELOPMENT OF NOTICE.—

“(i) IN GENERAL.—The Secretary, in coordination with the Commissioner of Social Security, and taking into consideration information collected pursuant to clause (ii), shall, not later than 12 months after the last day of the period for the request of information described in clause (ii), develop the notice to be provided pursuant to subparagraph (A).

“(ii) REQUEST FOR INFORMATION.—Not later than 6 months after the date of the enactment of this paragraph, the Secretary shall request written information, including recommendations, from stakeholders (including the groups described in subparagraph (D)) on the information to be included in the notice.
“(iii) NOTICE IMPROVEMENT.—Beginning 4 years after the date of enactment of this paragraph, and not less than once every two years thereafter, the Secretary, in coordination with the Commissioner of Social Security, shall—

“(I) review the content of the notice to be provided under subparagraph (A);

“(II) solicit recommendations on the notice through a request for information process as described in clause (ii); and

“(III) update and revise such notice as the Secretary deems appropriate.

“(D) GROUPS FOR CONSULTATION.—For purposes of subparagraph (C)(ii), the groups described in this clause include the following:

“(i) Individuals who are 60 years of age or older.

“(ii) Veterans.

“(iii) Individuals with disabilities.

“(iv) Individuals with end stage renal disease.

“(v) Low-income individuals and families.

“(vi) Employers (including human resources professionals).
“(vii) States (including representatives of State-run Health Insurance Exchanges, Medicaid offices, and Departments of Insurance).

“(viii) State Health Insurance Assistance Programs.

“(ix) Health insurers.

“(x) Health insurance agents and brokers.

“(xi) Such other groups as specified by the Secretary.

“(E) POSTING OF NOTICE ON WEBSITES.—The Commissioner of Social Security and the Secretary shall ensure that the notice being used under subparagraph (A) is posted in a prominent location on the public Internet website of the Social Security Administration and on the public Internet website of the Centers for Medicare & Medicaid Services, respectively.

“(F) REIMBURSEMENT OF COSTS.—

“(i) In general.—Effective for fiscal years beginning in the year in which the date of enactment of this paragraph occurs, the Commissioner of Social Security and the Secretary shall enter into an agreement which shall provide funding to cover the administrative
costs of the Commissioner’s activities under this paragraph. Such agreement shall—

“(I) provide funds to the Commissioner for the full cost of the Social Security Administration’s work related to the implementation of this paragraph, including any initial costs incurred prior to the finalization of such agreement;

“(II) provide such funding quarterly in advance of the applicable quarter based on estimating methodology agreed to by the Commissioner and the Secretary; and

“(III) require an annual accounting and reconciliation of the actual costs incurred and funds provided under this paragraph.

“(ii) LIMITATION.—In no case shall funds from the Social Security Administration’s Limitation on Administrative Expenses be used to carry out activities related to the implementation of this paragraph.

“(G) NO EFFECT ON OBLIGATION TO MAIL STATEMENTS.—Nothing in this paragraph shall be construed to relieve the Commissioner of Social Security from any requirement under subsection (e),
including the requirement to mail a statement on an annual basis to each eligible individual who is not receiving benefits under title II and for whom a mailing address can be determined through such methods as the Commissioner determines to be appropriate.”.

(2) INDIVIDUALS IN MEDICARE WAITING PERIOD.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1144 the following new section:

“MEDICARE ENROLLMENT NOTIFICATION AND ELIGIBILITY NOTICES FOR INDIVIDUALS IN MEDICARE WAITING PERIOD

“Sec. 1144A. (a)

“(1) IN GENERAL.—The Commissioner of Social Security shall distribute the notice to be provided pursuant to section 1143(a)(4), as may be modified under paragraph (2), to individuals in the 24-month waiting period under section 226(b).

“(2) AUTHORITY TO MODIFY NOTICE.—The Secretary, in coordination with the Commissioner of Social Security, may modify the notice to be distributed under paragraph (1) as necessary to take into account the individuals described in such paragraph.
“(3) Posting of Notice on Websites.—The Commissioner of Social Security and the Secretary shall ensure that the notice being used under paragraph (1) is posted in a prominent location on the public Internet website of the Social Security Administration and on the public Internet website of the Centers for Medicare & Medicaid Services, respectively.

“Timing

“(b) Beginning not later than 2 years after the date of the enactment of this section, a notice required under subsection (a)(1) shall be mailed to an individual no less than two times in accordance with the following:

“(1) The notice shall be provided to such individual not later than 3 months prior to the date on which such individual’s enrollment period begins as provided under section 1837.

“(2) The notice shall subsequently be provided to such individual not later than one month prior to such date.

“Reimbursement of Costs

“(c)

“(1) IN GENERAL.—Effective for fiscal years beginning in the year in which the date of enactment of this section occurs, the Commissioner of Social Security Administration shall ensure that the costs of mailing notices required under subsection (a)(1) are reimbursed by the Commissioner of Social Security Administration.
Security and the Secretary shall enter into an agreement which shall provide funding to cover the administrative costs of the Commissioner’s activities under this section. Such agreement shall—

“(A) provide funds to the Commissioner for the full cost of the Social Security Administration’s work related to the implementation of this section, including any initial costs incurred prior to the finalization of such agreement;

“(B) provide such funding quarterly in advance of the applicable quarter based on estimating methodology agreed to by the Commissioner and the Secretary; and

“(C) require an annual accounting and reconciliation of the actual costs incurred and funds provided under this section.

“(2) LIMITATION.—In no case shall funds from the Social Security Administration’s Limitation on Administrative Expenses be used to carry out activities related to the implementation of this section.”.

(b) BENEFICIARY ENROLLMENT SIMPLIFICATION.—

(1) EFFECTIVE DATE OF COVERAGE.—Section 1838(a) of the Social Security Act (42 U.S.C. 1395q(a)) is amended—
(A) by amending paragraph (2) to read as follows:

“(2)(A) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 before the month in which he first satisfies paragraph (1) or (2) of section 1836, the first day of such month,

“(B) in the case of an individual who first satisfies such paragraph in a month beginning before January 2021 and who enrolls pursuant to such subsection (d)—

“(i) in such month in which he first satisfies such paragraph, the first day of the month following the month in which he so enrolls,

“(ii) in the month following such month in which he first satisfies such paragraph, the first day of the second month following the month in which he so enrolls, or

“(iii) more than one month following such month in which he satisfies such paragraph, the first day of the third month following the month in which he so enrolls,

“(C) in the case of an individual who first satisfies such paragraph in a month beginning on or after January 1, 2021, and who enrolls pursuant to such subsection (d) in such month in which he first
satisfies such paragraph or in any subsequent month of his initial enrollment period, the first day of the month following the month in which he so enrolls, or

“(D) in the case of an individual who enrolls pursuant to subsection (e) of section 1837 in a month beginning—

“(i) before January 1, 2021, the July 1 following the month in which he so enrolls, or

“(ii) on or after January 1, 2021, the first day of the month following the month in which he so enrolls, or”; and

(B) by amending paragraph (3) to read as follows:

“(3) in the case of an individual who is deemed to have enrolled—

“(A) on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section 1836 or July 1, 1973, whichever is later, or

“(B) on or after the first day of the fourth month of his initial enrollment period, and where such month begins—

“(i) before January 1, 2021, as prescribed under subparagraphs (B)(i),
(B)(ii), (B)(iii), and (D) of paragraph (2),
or
“(ii) on or after January 1, 2021, as
prescribed under paragraph (2)(C).”.

(2) SPECIAL ENROLLMENT PERIODS FOR EX-
CEPTIONAL CIRCUMSTANCES.—

(A) ENROLLMENT.—Section 1837 of the
Social Security Act (42 U.S.C. 1395p) is
amended by adding at the end the following
new subsection:

“(m) Beginning January 1, 2021, the Secretary may
establish special enrollment periods in the case of individ-
uals who meet such exceptional conditions as the Secretary
may provide, such as individuals who reside in an area
with an emergency or disaster as determined by the Sec-
retary.”.

(B) COVERAGE PERIOD.—Section 1838 of
the Social Security Act (42 U.S.C. 1395q) is
amended by adding at the end the following
new subsection:

“(g) Notwithstanding subsection (a), in the case of
an individual who enrolls during a special enrollment pe-
riod pursuant to section 1837(m), the coverage period
shall begin on a date the Secretary provides in a manner
consistent (to the extent practicable) with protecting contin-

uity of health benefit coverage.”.

(C) CONFORMING AMENDMENT.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended, in the first sentence, by striking “or (l)” and inserting “, (l), or (m)”.

(3) TECHNICAL CORRECTION.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: “For purposes of determining any increase under this subsection for individuals whose enrollment occurs on or after January 1, 2021, the second sentence of this subsection shall be applied by substituting ‘close of the month’ for ‘close of the enrollment period’ each place it appears.”.

(4) REPORT.—Not later than January 1, 2021, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means and Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and Special Committee on Aging of the Senate a report including recommendations on how to align existing Medicare enrollment periods under title XVIII of the Social Security Act, including the general enrollment period under part B of such title and the
annual election period under the Medicare Advantage program under part C of such title and under the prescription drug program under part D of such title. Such recommendations shall be consistent with the goals of maximizing coverage continuity and choice and easing beneficiary transition.

SEC. 102. EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.


(1) in clause (vii), by striking “and” at the end;

(2) in clause (viii), by striking “and” at the end;
(3) in clause (ix), by striking the period at the end and inserting ‘‘; and’’; and

(4) by inserting after clause (ix) the following new clause:

‘‘(x) for each of fiscal years 2020 through 2022, of $15,000,000.’’.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (vii), by striking ‘‘and’’ at the end;

(2) in clause (viii), by striking ‘‘and’’ at the end;

(3) in clause (ix), by striking the period at the end and inserting ‘‘; and’’; and

(4) by inserting after clause (ix) the following new clause:

‘‘(x) for each of fiscal years 2020 through 2022, of $15,000,000.’’.

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (vii), by striking ‘‘and’’ at the end;

(2) in clause (viii), by striking ‘‘and’’ at the end;
(3) in clause (ix), by striking the period at the end and inserting “; and”; and

(4) by inserting after clause (ix) the following new clause:

“(x) for each of fiscal years 2020 through 2022, of $5,000,000.”.

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119, as so amended, is amended—

(1) in clause (vii), by striking “and” at the end;

(2) in clause (viii), by striking “and” at the end;

(3) in clause (ix), by striking the period at the end and inserting “; and”; and

(4) by inserting after clause (ix) the following new clause:

“(x) for each of fiscal years 2020 through 2022, of $15,000,000.”.

SEC. 103. MEDICARE COVERAGE OF CERTAIN MENTAL HEALTH TELEHEALTH SERVICES.

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—
(1) in paragraph (2)(B)(i), by striking “and paragraph (6)(C)” and inserting “, paragraph (6)(C), and paragraph (8)(C)”;

(2) in paragraph (4)(C)(i), by striking “and (7)” and inserting “(7), and (8)”;

(3) in paragraph (4)(F)(i), by inserting “services identified by CPT codes 90834 and 90837 (and as subsequently modified by the Secretary),” before “and any additional service”;

(4) in paragraph (6)(A), by striking “paragraph (4)(C)” and inserting “paragraph (4)(C)(i)”;

(5) in paragraph (7), by striking “The geographic requirements” and inserting “Subject to paragraph (8)(D), the geographic requirements”; and

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

“(8) TREATMENT OF MENTAL HEALTH TELE-HEALTH SERVICES.—

“(A) NON-APPLICATION OF ORIGINATING SITE REQUIREMENTS.—The requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after January 1, 2020, that are mental health telehealth services. Nothing in the pre-
vious sentence shall waive any applicable State law requirements.

“(B) INCLUSION OF CERTAIN SITES.—
With respect to telehealth services described in subparagraph (A), the term ‘originating site’ shall include the home of the eligible telehealth individual at which the individual is located at the time the service is furnished via a telecommunications system.

“(C) NO ORIGINATING SITE FACILITY FEE.—No facility fee shall be paid under paragraph (2)(B) to an originating site with respect to a telehealth service described in subparagraph (A) if the originating site does not otherwise meet the requirements for an originating site under paragraph (4)(C).

“(D) FACE-TO-FACE INITIAL ASSESSMENT; REASSESSMENTS.—Payment may not be made for mental health telehealth services under this paragraph (if such payment would not otherwise be allowed under this subsection without application of this paragraph or paragraph (7)) furnished to an eligible telehealth individual unless—
“(i) within the 6-month period prior to the provision of such mental health telehealth services, the individual receives a face-to-face clinical assessment, without the use of telehealth, by a physician described in subparagraph (F)(i) or a practitioner described in subparagraph (F)(ii) of the needs of such individual for such services; and

“(ii) the individual receives a reassessment (at a frequency specified by the Secretary) by a physician so described or a practitioner so described of the needs of such individual for such services.

“(E) Mental health telehealth services defined.—For purposes of this paragraph, the term ‘mental health telehealth service’ means services identified by CPT codes 90834 and 90837 (and as subsequently modified by the Secretary).

“(F) Physician and practitioner described.—For purposes of subparagraph (D):

“(i) Physician.—A physician described in this clause is a physician, as defined in section 1861(r)(1).
“(ii) Practitioner.—A practitioner described in this clause is a practitioner described in any of clauses (i), (iv), or (v) of section 1842(b)(18)(C).”.

SEC. 104. REQUIRING PRESCRIPTION DRUG PLAN SPONSORS TO INCLUDE REAL-TIME BENEFIT INFORMATION AS PART OF SUCH SPONSOR’S ELECTRONIC PRESCRIPTION PROGRAM UNDER THE MEDICARE PROGRAM.

Section 1860D–4(e)(2) of the Social Security Act (42 U.S.C. 1395w–104(e)(2)) is amended—

(1) in subparagraph (D), by striking “To the extent” and inserting “Except as provided in subparagraph (F), to the extent”; and

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

“(F) Real-time benefit information.—

“(i) In general.—Not later than January 1, 2021, the program shall provide for the real-time electronic transmission to prescribing health care professionals, using technology capable of integrating with such professionals’ electronic prescribing and electronic health record
systems, of individual-specific formulary and benefit information under a prescription drug plan with respect to an individual enrolled in such plan. Such information shall include, with respect to the prescribing of a covered part D drug to such individual, the following:

“(I) A description of any clinically-appropriate alternatives to such drug included in the formulary of such plan.

“(II) Information relating to applicable cost-sharing requirements for such drug and such alternatives, including a description of any variance in such requirements based on the pharmacy dispensing such drug or such alternatives.

“(III) Information relating to any prior authorization or other utilization management requirements applicable to such drug and such alternatives within the formulary of such plan.
“(ii) Special rule for 2021.—The program shall be deemed to be in compliance with clause (i) for 2021 if the program complies with the provisions of section 423.160(b)(7) of title 42, Code of Federal Regulations (or a successor regulation), for such year.”.

SEC. 105. TRANSITIONAL COVERAGE AND RETROACTIVE MEDICARE PART D COVERAGE FOR CERTAIN LOW-INCOME BENEFICIARIES.

Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) is amended—

(1) by redesignating subsection (e) as subsection (f); and

(2) by adding after subsection (d) the following new subsection:

“(e) Limited Income Newly Eligible Transition Program.—

“(1) In general.—Beginning not later than January 1, 2021, the Secretary shall carry out a program to provide transitional coverage for covered part D drugs for LI NET eligible individuals in accordance with this subsection.

“(2) LI NET eligible individual defined.—For purposes of this subsection, the term ‘LI NET
eligible individual’ means a part D eligible individual
who—

“(A) meets the requirements of clauses (ii)
and (iii) of subsection (a)(3)(A); and

“(B) has not yet enrolled in a prescription
drug plan or an MA–PD plan, or, who has so
enrolled, but with respect to whom coverage
under such plan has not yet taken effect.

“(3) TRANSITIONAL COVERAGE.—For purposes
of this subsection, the term ‘transitional coverage’
means with respect to an LI NET eligible indi-
vidual—

“(A) immediate access to covered part D
drugs at the point of sale during the period
that begins on the first day of the month such
individual is determined to meet the require-
ments of clauses (ii) and (iii) of subsection
(a)(3)(A) and ends on the date that coverage
under a prescription drug plan or MA–PD plan
takes effect with respect to such individual; and

“(B) in the case of an LI NET eligible indi-
vidual who is a full-benefit dual eligible indi-
vidual (as defined in section 1935(c)(6)) or a
recipient of supplemental security income bene-
fits under title XVI, retroactive coverage (in the
form of reimbursement of the amounts that would have been paid under this part had such individual been enrolled in a prescription drug plan or MA–PD plan) of covered part D drugs purchased by such individual during the period that begins on the date that is the later of—

“(i) the date that such individual was first eligible for a low-income subsidy under this part; or

“(ii) the date that is 36 months prior to the date such individual enrolls in a pre-
scription drug plan or MA–PD plan, and ends on the date that coverage under such plan takes effect.

“(4) PROGRAM ADMINISTRATION.—

“(A) SINGLE POINT OF CONTACT.—The Secretary shall, to the extent feasible, admin-
ister the program under this subsection through a contract with a single program administrator.

“(B) BENEFIT DESIGN.—The Secretary shall ensure that the transitional coverage pro-
vided to LI NET eligible individuals under this subsection—

“(i) provides access to all covered part D drugs under an open formulary;
“(ii) permits all pharmacies determined by the Secretary to be in good standing to process claims under the program;

“(iii) is consistent with such requirements as the Secretary considers necessary to improve patient safety and ensure appropriate dispensing of medication; and

“(iv) meets such other requirements as the Secretary may establish.

“(5) RELATIONSHIP TO OTHER PROVISIONS OF THIS TITLE; WAIVER AUTHORITY.—

“(A) IN GENERAL.—The following provisions shall not apply with respect to the program under this subsection:

“(i) Paragraphs (1) and (3)(B) of section 1860D–4(a) (relating to dissemination of general information; availability of information on changes in formulary through the Internet).

“(ii) Subparagraphs (A) and (B) of section 1860D–4(b)(3) (relating to requirements on development and application of formularies; formulary development).
“(iii) Paragraphs (1)(C) and (2) of section 1860D–4(c) (relating to medication therapy management program).

“(B) WAIVER AUTHORITY.—The Secretary may waive such other requirements of title XI and this title as may be necessary to carry out the purposes of the program established under this subsection.”.

TITLE II—RURAL AND QUALITY IMPROVEMENTS

SEC. 201. MEDICARE GME TREATMENT OF HOSPITALS ESTABLISHING NEW MEDICAL RESIDENCY TRAINING PROGRAMS AFTER HOSTING MEDICAL RESIDENT ROTATORS FOR SHORT DURATIONS.

(a) Redetermination of Approved FTE Resident Amount.—Section 1886(h)(2)(F) of the Social Security Act (42 U.S.C. 1395ww(h)(2)(F)) is amended—

(1) by inserting “(i)” before “In the case of”; and

(2) by adding at the end the following:

“(ii) In applying this subparagraph in the case of a hospital that, on or after the date of the enactment of this clause, begins to train residents and has not entered into a GME af-
filiation agreement (as defined by the Secretary for purposes of paragraph (4)(H)(ii)), the Secretary shall not establish an FTE resident amount until such time as the Secretary determines that the hospital has trained at least 1.0 full-time-equivalent resident in an approved medical residency training program in a cost reporting period.

“(iii) In applying this subparagraph for cost reporting periods beginning on or after the date of enactment of this clause, in the case of a hospital that, as of such date of enactment, has an approved FTE resident amount based on the training in an approved medical residency program of—

“(I) less than 1.0 full-time-equivalent resident in any cost reporting period beginning before October 1, 1997, as determined by the Secretary; or

“(II) no more than 3.0 full-time-equivalent residents in any cost reporting period beginning on or after October 1, 1997, and before the date of the enactment of this clause, as determined by the Secretary,
in lieu of such FTE resident amount the Secretary shall, in accordance with the methodology described in section 413.77(e) of title 42 of the Code of Federal Regulations (or any successor regulation), establish a new FTE resident amount if the hospital trains at least 1.0 full-time-equivalent resident (in the case of a hospital described in subclause (I)) or more than 3.0 full-time-equivalent residents (in the case of a hospital described in subclause (II)) in a cost reporting period beginning on or after such date of enactment and before the date that is 5 years after such date of enactment.

“(iv) For purposes of carrying out this subparagraph for cost reporting periods beginning on or after the date of the enactment of this clause, a hospital shall report full-time-equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent resident in an approved medical residency training program in such period.

“(v) As appropriate, the Secretary may consider information from any cost reporting
period necessary to establish a new FTE resident amount as described in clause (iii).”.

(b) Redetermination of FTE Resident Limitation.—Section 1886(h)(4)(H)(i) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(i)) is amended—

(1) by inserting “(I)” before “The Secretary”; and

(2) by adding at the end the following:

“(II) In applying this clause in the case of a hospital that, on or after the date of the enactment of this subclause, begins to train residents in a new approved medical residency training program (as defined by the Secretary), the Secretary shall not determine a limitation applicable to the hospital under subparagraph (F) until such time as the Secretary determines that the hospital has trained at least 1.0 full-time-equivalent resident in such new approved medical residency training program in a cost reporting period.

“(III) In applying this clause in the case of a hospital that, as of the date of the enactment of this subclause, has a limitation under subparagraph (F), based on
a cost reporting period beginning before October 1, 1997, of less than 1.0 full-time-equivalent resident, the Secretary shall adjust the limitation in the manner applicable to a new approved medical residency training program if the Secretary determines the hospital trains at least 1.0 full-time-equivalent resident in a program year beginning on or after such date of enactment and before the date that is 5 years after such date of enactment.

“(IV) In applying this clause in the case of a hospital that, as of the date of the enactment of this subclause, has a limitation under subparagraph (F), based on a cost reporting period beginning on or after October 1, 1997, and before such date of enactment, of no more than 3.0 full-time-equivalent residents, the Secretary shall adjust the limitation in the manner applicable to a new approved medical residency training program if the Secretary determines the hospital begins training more than 3.0 full-time-equivalent residents in a program year beginning on or
after such date of enactment and before
the date that is 5 years after such date of
enactment.

“(V) An adjustment to the limitation
applicable to a hospital made pursuant to
subclause (III) or (IV) shall be made in a
manner consistent with the methodology,
as appropriate, in section 413.79(e) of title
42, Code of Federal Regulations (or any
successor regulation). As appropriate, the
Secretary may consider information from
any cost reporting periods necessary to
make such an adjustment to the limita-
tion.”

(c) TECHNICAL AND CONFORMING AMENDMENTS.—
Section 1886 of the Social Security Act (42 U.S.C.
1395ww) is amended—

(1) in subsection (d)(5)(B)(viii), by striking
“subsection (h)(4)(H)” and inserting “paragraphs
(2)(F)(iv) and (4)(H) of subsection (h)”;

(2) in subsection (h)—

(2) in subsection (h)—

(A) in paragraph (4)(H)(iv), by striking
“an rural area” and inserting “a rural area”;

and
in paragraph (7)(E), by striking
“under this” and all that follows through the
period at the end and inserting the following:
“under this paragraph, paragraph (8), clause
(i), (ii), (iii), or (v) of paragraph (2)(F), or
clause (i) or (vi) of paragraph (4)(H).”.
(d) EFFECTIVE DATE.—The amendments made by
this section shall apply to payment under section 1886 of
the Social Security Act (42 U.S.C. 1395ww) for cost re-
porting periods beginning on or after the date of the en-
actment of this Act.

SEC. 202. EXTENSION OF THE WORK GEOGRAPHIC INDEX
FLOOR UNDER THE MEDICARE PROGRAM.
Section 1848(e)(1)(E) of the Social Security Act (42
and inserting “2023”.

SEC. 203. EXTENSION OF FUNDING FOR QUALITY MEASURE
ENDORSEMENT, INPUT, AND SELECTION
UNDER MEDICARE PROGRAM.
(a) IN GENERAL.—Section 1890(d)(2) of the Social
Security Act (42 U.S.C. 1395aaa(d)(2)) is amended—
(1) by striking “and $7,500,000” and inserting
“$7,500,000”; and
(2) by striking “and 2019.” and inserting “and 2019, and $30,000,000 for each of fiscal years 2020 through 2022.”.

(b) Input for Removal of Measures.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by inserting after paragraph (3) the following:

“(4) Removal of Measures.—The entity may provide input to the Secretary on quality and efficiency measures described in paragraph (7)(B) that could be considered for removal.”.

(c) Prioritization of Measure Endorsement.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by adding at the end the following:

“(9) Prioritization of Measure Endorsement.—The Secretary—

“(A) during the period beginning on the date of the enactment of this paragraph and ending on December 31, 2023, shall prioritize the endorsement of measures relating to maternal morbidity and mortality by the entity with a contract under subsection (a) in connection with endorsement of measures described in paragraph (2); and
“(B) on and after January 1, 2024, may prioritize the endorsement of such measures by such entity.”.

SEC. 204. IMPROVING MEASUREMENTS UNDER THE SKILLED NURSING FACILITY VALUE-BASED PURCHASING PROGRAM UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1888(h) of the Social Security Act (42 U.S.C. 1395yy(h)) is amended—

(1) in paragraph (1), by adding at the end the following new subparagraph:

“(C) EXCLUSIONS.—With respect to payments for services furnished on or after October 1, 2021, this subsection shall not apply to a facility for which there are not a minimum number (as determined by the Secretary) of—

“(i) cases for the measures that apply to the facility for the performance period for the applicable fiscal year; or

“(ii) measures that apply to the facility for the performance period for the applicable fiscal year.”;

(2) in paragraph (2)(A)—

(A) by striking “The Secretary shall apply” and inserting “The Secretary—
“(i) shall apply”;

(B) by striking the period at the end and
inserting “; and”; and

(C) by adding at the end the following:

“(ii) may, with respect to payments
for services furnished on or after October
1, 2022, apply additional measures deter-
mined appropriate by the Secretary, which
may include measures of functional status,
patient safety, care coordination, or patient
experience.

Subject to the succeeding sentence, in the case
that the Secretary applies additional measures
under clause (ii), the Secretary shall consider
and apply, as appropriate, quality measures
specified under section 1899B(e)(1). In no case
may the Secretary apply more than 10 meas-
ures under this subparagraph.”;

(3) in subparagraph (A) of each of paragraphs
(3) and (4), by striking “measure” and inserting
“measures”; and

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

“(12) VALIDATION.—
“(A) IN GENERAL.—The Secretary shall apply to the measures applied under this sub-
section and the data submitted under sub-
section (e)(6) a process to validate such meas-
ures and data, as appropriate, which may be similar to the process specified in section
1886(b)(3)(B)(viii)(XI) for validating inpatient hospital measures.

“(B) FUNDING.—For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Hospital Ins-
surance Trust Fund established under section 1817, of $5,000,000 to the Centers for Medi-
care & Medicaid Services Program Management Account for each of fiscal years 2022 through 2024.”.

(b) REPORT BY MEDPAC.—Not later than March 15, 2021, the Medicare Payment Advisory Commission shall submit to Congress a report on establishing a proto-
type value-based payment program under a unified pro-
spective payment system for post-acute care services under the Medicare program under title XVIII of the Social Se-
curity Act (42 U.S.C. 1395 et seq.). Such report—

(1) shall—

(A) consider design elements such as—
(i) measures that are important to the Medicare program and to beneficiaries under such program;

(ii) methodologies for scoring provider performance and effects on payment; and

(iii) other elements determined appropriate by the Commission; and

(B) analyze the effects of implementing such prototype program; and

(2) may—

(A) discuss the possible effects, with respect to the Medicare program, on program spending, post-acute care providers, patient outcomes, and other effects determined appropriate by the Commission; and

(B) include recommendations with respect to such prototype program, as determined appropriate by the Commission, to Congress and the Secretary of Health and Human Services.