

114TH CONGRESS
1ST SESSION

H. R. 2

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children's Health Insurance Program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 24, 2015

Mr. BURGESS (for himself, Mr. UPTON, Mr. LEVIN, Mr. RYAN of Wisconsin, Mr. PALLONE, Mr. PITTS, Mr. GENE GREEN of Texas, Mr. BRADY of Texas, Mr. McDERMOTT, Mr. BOUSTANY, and Mr. SESSIONS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, the Judiciary, Agriculture, Natural Resources, and the Budget, 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 repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children's Health Insurance Program, and for other purposes.

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

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

2 (a) SHORT TITLE.—This Act may be cited as the
3 “Medicare Access and CHIP Reauthorization Act of
4 2015”.

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—SGR REPEAL AND MEDICARE PROVIDER PAYMENT
MODERNIZATION**

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. Empowering beneficiary choices through continued access to informa-
tion on physicians’ services.

Sec. 105. Expanding availability of Medicare data.

Sec. 106. Reducing administrative burden and other provisions.

TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS

Subtitle A—Medicare Extenders

Sec. 201. Extension of work GPCI floor.

Sec. 202. Extension of therapy cap exceptions process.

Sec. 203. Extension of ambulance add-ons.

Sec. 204. Extension of increased inpatient hospital payment adjustment for cer-
tain low-volume hospitals.

Sec. 205. Extension of the Medicare-dependent hospital (MDH) program.

Sec. 206. Extension for specialized Medicare Advantage plans for special needs
individuals.

Sec. 207. Extension of funding for quality measure endorsement, input, and se-
lection.

Sec. 208. Extension of funding outreach and assistance for low-income pro-
grams.

Sec. 209. Extension and transition of reasonable cost reimbursement contracts.

Sec. 210. Extension of home health rural add-on.

Subtitle B—Other Health Extenders

Sec. 211. Permanent extension of the qualifying individual (QI) program.

Sec. 212. Permanent extension of transitional medical assistance (TMA).

Sec. 213. Extension of special diabetes program for type I diabetes and for In-
dians.

Sec. 214. Extension of abstinence education.

Sec. 215. Extension of personal responsibility education program (PREP).

Sec. 216. Extension of funding for family-to-family health information centers.

- Sec. 217. Extension of health workforce demonstration project for low-income individuals.
- Sec. 218. Extension of maternal, infant, and early childhood home visiting programs.
- Sec. 219. Tennessee DSH allotment for fiscal years 2015 through 2025.
- Sec. 220. Delay in effective date for Medicaid amendments relating to beneficiary liability settlements.
- Sec. 221. Extension of funding for community health centers, the National Health Service Corps, and teaching health centers.

TITLE III—CHIP

- Sec. 301. 2-year extension of the Children’s Health Insurance Program.
- Sec. 302. Extension of express lane eligibility.
- Sec. 303. Extension of outreach and enrollment program.
- Sec. 304. Extension of certain programs and demonstration projects.
- Sec. 305. Report of Inspector General of HHS on use of express lane option under Medicaid and CHIP.

TITLE IV—OFFSETS

Subtitle A—Medicare Beneficiary Reforms

- Sec. 401. Limitation on certain medigap policies for newly eligible Medicare beneficiaries.
- Sec. 402. Income-related premium adjustment for parts B and D.

Subtitle B—Other Offsets

- Sec. 411. Medicare payment updates for post-acute providers.
- Sec. 412. Delay of reduction to Medicaid DSH allotments.
- Sec. 413. Levy on delinquent providers.
- Sec. 414. Adjustments to inpatient hospital payment rates.

TITLE V—MISCELLANEOUS

Subtitle A—Protecting the Integrity of Medicare

- Sec. 501. Prohibition of inclusion of Social Security account numbers on Medicare cards.
- Sec. 502. Preventing wrongful Medicare payments for items and services furnished to incarcerated individuals, individuals not lawfully present, and deceased individuals.
- Sec. 503. Consideration of measures regarding Medicare beneficiary smart cards.
- Sec. 504. Modifying Medicare durable medical equipment face-to-face encounter documentation requirement.
- Sec. 505. Reducing improper Medicare payments.
- Sec. 506. Improving senior Medicare patrol and fraud reporting rewards.
- Sec. 507. Requiring valid prescriber National Provider Identifiers on pharmacy claims.
- Sec. 508. Option to receive Medicare Summary Notice electronically.
- Sec. 509. Renewal of MAC contracts.
- Sec. 510. Study on pathway for incentives to States for State participation in medicaid data match program.
- Sec. 511. Guidance on application of Common Rule to clinical data registries.

- Sec. 512. Eliminating certain civil money penalties; gainsharing study and report.
- Sec. 513. Modification of Medicare home health surety bond condition of participation requirement.
- Sec. 514. Oversight of Medicare coverage of manual manipulation of the spine to correct subluxation.
- Sec. 515. National expansion of prior authorization model for repetitive scheduled non-emergent ambulance transport.
- Sec. 516. Repealing duplicative Medicare secondary payor provision.
- Sec. 517. Plan for expanding data in annual CERT report.
- Sec. 518. Removing funds for Medicare Improvement Fund added by IMPACT Act of 2014.
- Sec. 519. Rule of construction.

Subtitle B—Other Provisions

- Sec. 521. Extension of two-midnight PAMA rules on certain medical review activities.
- Sec. 522. Requiring bid surety bonds and State licensure for entities submitting bids under the Medicare DMEPOS competitive acquisition program.
- Sec. 523. Payment for global surgical packages.
- Sec. 524. Extension of Secure Rural Schools and Community Self-Determination Act of 2000.
- Sec. 525. Exclusion from PAYGO scorecards.

1 **TITLE I—SGR REPEAL AND** 2 **MEDICARE PROVIDER PAY-** 3 **MENT MODERNIZATION**

4 **SEC. 101. REPEALING THE SUSTAINABLE GROWTH RATE** 5 **(SGR) AND IMPROVING MEDICARE PAYMENT** 6 **FOR PHYSICIANS' SERVICES.**

7 (a) STABILIZING FEE UPDATES.—

8 (1) REPEAL OF SGR PAYMENT METHOD-
9 OLOGY.—Section 1848 of the Social Security Act
10 (42 U.S.C. 1395w–4) is amended—

11 (A) in subsection (d)—

12 (i) in paragraph (1)(A)—

1 (I) by inserting “and ending with
2 2025” after “beginning with 2001”;
3 and

4 (II) by inserting “or a subse-
5 quent paragraph” after “paragraph
6 (4)”; and

7 (ii) in paragraph (4)—

8 (I) in the heading, by inserting
9 “AND ENDING WITH 2014” after
10 “YEARS BEGINNING WITH 2001”; and

11 (II) in subparagraph (A), by in-
12 serting “and ending with 2014” after
13 “a year beginning with 2001”; and

14 (B) in subsection (f)—

15 (i) in paragraph (1)(B), by inserting
16 “through 2014” after “of each succeeding
17 year”; and

18 (ii) in paragraph (2), in the matter
19 preceding subparagraph (A), by inserting
20 “and ending with 2014” after “beginning
21 with 2000”.

22 (2) UPDATE OF RATES FOR 2015 AND SUBSE-
23 QUENT YEARS.—Subsection (d) of section 1848 of
24 the Social Security Act (42 U.S.C. 1395w-4) is
25 amended—

(A) in paragraph (1)(A), by adding at the end the following: “There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant (as defined in section 1833(z)(2)) (referred to in this subsection as the ‘qualifying APM conversion factor’) and the other for other items and services (referred to in this subsection as the ‘nonqualifying APM conversion factor’), equal to the respective conversion factor for the previous year (or, in the case of 2026, equal to the single conversion factor for 2025) multiplied by the update established under paragraph (20) for such respective conversion factor for such year.”;

(B) in paragraph (1)(D), by inserting “(or, beginning with 2026, applicable conversion factor)” after “single conversion factor”; and

(C) by striking paragraph (16) and inserting the following new paragraphs:

“(16) UPDATE FOR JANUARY THROUGH JUNE OF 2015.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B), and (15)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that

would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on June 30, 2015, the update to the single conversion factor shall be 0.0 percent.

“(17) UPDATE FOR JULY THROUGH DECEMBER OF 2015.—The update to the single conversion factor established in paragraph (1)(C) for the period beginning on July 1, 2015, and ending on December 31, 2015, shall be 0.5 percent.

“(18) UPDATE FOR 2016 THROUGH 2019.—The update to the single conversion factor established in paragraph (1)(C) for 2016 and each subsequent year through 2019 shall be 0.5 percent.

“(19) UPDATE FOR 2020 THROUGH 2025.—The update to the single conversion factor established in paragraph (1)(C) for 2020 and each subsequent year through 2025 shall be 0.0 percent.

“(20) UPDATE FOR 2026 AND SUBSEQUENT YEARS.—For 2026 and each subsequent year, the update to the qualifying APM conversion factor established under paragraph (1)(A) is 0.75 percent, and the update to the nonqualifying APM conversion factor established under such paragraph is 0.25 percent.”.

(3) MEDPAC REPORTS.—

1 (A) INITIAL REPORT.—Not later than July
2 1, 2017, the Medicare Payment Advisory Com-
3 mission shall submit to Congress a report on
4 the relationship between—

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

12 (ii) total utilization and expenditures
13 (and the rate of increase of such utilization
14 and expenditures) under parts A, B, and D
15 of title XVIII of such Act.

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

22 (B) FINAL REPORT.—Not later than July
23 1, 2021, the Medicare Payment Advisory Com-
24 mission shall submit to Congress a report on
25 the relationship described in subparagraph (A),

1 including the results determined from applying
2 the methodology included in the report sub-
3 mitted under such subparagraph.

4 (C) REPORT ON UPDATE TO PHYSICIANS'
5 SERVICES UNDER MEDICARE.—Not later than
6 July 1, 2019, the Medicare Payment Advisory
7 Commission shall submit to Congress a report
8 on—

9 (i) the payment update for profes-
10 sional services applied under the Medicare
11 program under title XVIII of the Social
12 Security Act for the period of years 2015
13 through 2019;

14 (ii) the effect of such update on the
15 efficiency, economy, and quality of care
16 provided under such program;

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

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

1 (b) CONSOLIDATION OF CERTAIN CURRENT LAW
2 PERFORMANCE PROGRAMS WITH NEW MERIT-BASED IN-
3 CENTIVE PAYMENT SYSTEM.—

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

6 (A) SUNSETTING SEPARATE MEANINGFUL
7 USE PAYMENT ADJUSTMENTS.—Section
8 1848(a)(7)(A) of the Social Security Act (42
9 U.S.C. 1395w-4(a)(7)(A)) is amended—

10 (i) in clause (i), by striking “2015 or
11 any subsequent payment year” and insert-
12 ing “each of 2015 through 2018”;

13 (ii) in clause (ii)(III), by striking
14 “each subsequent year” and inserting
15 “2018”; and

16 (iii) in clause (iii)—

17 (I) in the heading, by striking
18 “AND SUBSEQUENT YEARS”;

19 (II) by striking “and each subse-
20 quent year”; and

21 (III) by striking “, but in no case
22 shall the applicable percent be less
23 than 95 percent”.

24 (B) CONTINUATION OF MEANINGFUL USE
25 DETERMINATIONS FOR MIPS.—Section

1 1848(o)(2) of the Social Security Act (42
2 U.S.C. 1395w-4(o)(2)) is amended—

3 (i) in subparagraph (A), in the matter
4 preceding clause (i)—

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

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

14 (ii) by adding at the end the following
15 new subparagraph:

16 “(D) CONTINUED APPLICATION FOR PUR-
17 POSES OF MIPS.—With respect to 2019 and
18 each subsequent payment year, the Secretary
19 shall, for purposes of subsection (q) and in ac-
20 cordance with paragraph (1)(F) of such sub-
21 section, determine whether an eligible profes-
22 sional who is a MIPS eligible professional (as
23 defined in subsection (q)(1)(C)) for such year is
24 a meaningful EHR user under this paragraph

for the performance period under subsection (q)
for such year.”.

(2) QUALITY REPORTING.—

(A) SUNSETTING SEPARATE QUALITY REPORTING INCENTIVES.—Section 1848(a)(8)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(8)(A)) is amended—

(i) in clause (i), by striking “2015 or any subsequent year” and inserting “each of 2015 through 2018”; and

(ii) in clause (ii)(II), by striking “and each subsequent year” and inserting “, 2017, and 2018”.

(B) CONTINUATION OF QUALITY MEASURES AND PROCESSES FOR MIPS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

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

“(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection—

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

“(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.”; and

(ii) in subsection (m)—

(I) by redesignating paragraph (7) added by section 10327(a) of Public Law 111–148 as paragraph (8); and

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

“(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection—

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

“(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.”.

(3) VALUE-BASED PAYMENTS.—

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

1 “(iii) APPLICATION.—The Secretary
 2 shall apply the payment modifier estab-
 3 lished under this subsection for items and
 4 services furnished on or after January 1,
 5 2015, with respect to specific physicians
 6 and groups of physicians the Secretary de-
 7 termines appropriate, and for services fur-
 8 nished on or after January 1, 2017, with
 9 respect to all physicians and groups of
 10 physicians. Such payment modifier shall
 11 not be applied for items and services fur-
 12 nished on or after January 1, 2019.”.

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 2019

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 Notwithstanding subparagraph (C)(ii), under
11 the MIPS, the Secretary shall permit any eligi-
12 ble professional (as defined in subsection
13 (k)(3)(B)) to report on applicable measures and
14 activities described in paragraph (2)(B).

15 “(B) PROGRAM IMPLEMENTATION.—The
16 MIPS shall apply to payments for items and
17 services furnished on or after January 1, 2019.

18 “(C) MIPS ELIGIBLE PROFESSIONAL DE-
19 FINED.—

20 “(i) IN GENERAL.—For purposes of
21 this subsection, subject to clauses (ii) and
22 (iv), the term ‘MIPS eligible professional’
23 means—

24 “(I) for the first and second
25 years for which the MIPS applies to

1 payments (and for the performance
2 period for such first and second year),
3 a physician (as defined in section
4 1861(r)), a physician assistant, nurse
5 practitioner, and clinical nurse spe-
6 cialist (as such terms are defined in
7 section 1861(aa)(5)), a certified reg-
8 istered nurse anesthetist (as defined
9 in section 1861(bb)(2)), and a group
10 that includes such professionals; and

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

22 “(ii) EXCLUSIONS.—For purposes of
23 clause (i), the term ‘MIPS eligible profes-
24 sional’ does not include, with respect to a

1 year, an eligible professional (as defined in
2 subsection (k)(3)(B)) who—

3 “(I) is a qualifying APM partici-
4 pant (as defined in section
5 1833(z)(2));

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

17 “(III) for the performance period
18 with respect to such year, does not ex-
19 ceed the low-volume threshold meas-
20 urement selected under clause (iv).

21 “(iii) PARTIAL QUALIFYING APM PAR-
22 TICIPANT.—For purposes of this subpara-
23 graph, the term ‘partial qualifying APM
24 participant’ means, with respect to a year,
25 an eligible professional for whom the Sec-

1 retary determines the minimum payment
2 percentage (or percentages), as applicable,
3 described in paragraph (2) of section
4 1833(z) for such year have not been satis-
5 fied, but who would be considered a quali-
6 fying APM participant (as defined in such
7 paragraph) for such year if—

8 “(I) with respect to 2019 and
9 2020, the reference in subparagraph
10 (A) of such paragraph to 25 percent
11 was instead a reference to 20 percent;

12 “(II) with respect to 2021 and
13 2022—

14 “(aa) the reference in sub-
15 paragraph (B)(i) of such para-
16 graph to 50 percent was instead
17 a reference to 40 percent; and

18 “(bb) the references in sub-
19 paragraph (B)(ii) of such para-
20 graph to 50 percent and 25 per-
21 cent of such paragraph were in-
22 stead references to 40 percent
23 and 20 percent, respectively; and

24 “(III) with respect to 2023 and
25 subsequent years—

1 “(aa) the reference in sub-
2 paragraph (C)(i) of such para-
3 graph to 75 percent was instead
4 a reference to 50 percent; and

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

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

17 “(I) The minimum number (as
18 determined by the Secretary) of indi-
19 viduals enrolled under this part who
20 are treated by the eligible professional
21 for the performance period involved.

22 “(II) The minimum number (as
23 determined by the Secretary) of items
24 and services furnished to individuals

1 enrolled under this part by such pro-
2 fessional for such performance period.

3 “(III) The minimum amount (as
4 determined by the Secretary) of al-
5 lowed charges billed by such profes-
6 sional under this part for such per-
7 formance period.

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

22 “(vi) CLARIFICATION.—In the case of
23 items and services furnished during a year
24 by an individual who is not a MIPS eligible
25 professional (including pursuant to clauses

(ii) and (v)) with respect to a year, in no case shall a MIPS adjustment factor (or additional MIPS adjustment factor) under paragraph (6) apply to such individual for such year.

“(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATIONS.—

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

“(II) NOT ELIGIBLE FOR QUALIFYING APM PARTICIPANT PAYMENTS.—In no case shall an eligible professional who is a partial qualifying APM participant, with respect

to a year, be considered a qualifying APM participant (as defined in paragraph (2) of section 1833(z)) for such year or be eligible for the additional payment under paragraph (1) of such section for such year.

“(D) APPLICATION TO GROUP PRACTICES.—

“(i) IN GENERAL.—Under the MIPS:

“(I) QUALITY PERFORMANCE CATEGORY.—The Secretary shall establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

“(II) OTHER PERFORMANCE CATEGORIES.—The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with

1 respect to assessing the performance
2 of such group with respect to the per-
3 formance categories described in
4 clauses (ii) through (iv) of such para-
5 graph.

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

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

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

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

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

4 “(G) ACCOUNTING FOR RISK FACTORS.—

5 “(i) RISK FACTORS.—Taking into ac-
6 count the relevant studies conducted and
7 recommendations made in reports under
8 section 2(d) of the Improving Medicare
9 Post-Acute Care Transformation Act of
10 2014, and, as appropriate, other informa-
11 tion, including information collected before
12 completion of such studies and rec-
13 ommendations, the Secretary, on an ongo-
14 ing basis, shall, as the Secretary deter-
15 mines appropriate and based on an individ-
16 ual’s health status and other risk factors—

17 “(I) assess appropriate adjust-
18 ments to quality measures, resource
19 use measures, and other measures
20 used under the MIPS; and

21 “(II) assess and implement ap-
22 propriate adjustments to payment ad-
23 justments, composite performance
24 scores, scores for performance cat-

1 egories, or scores for measures or ac-
 2 tivities under the MIPS.

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

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

11 “(i) Quality.

12 “(ii) Resource use.

13 “(iii) Clinical practice improvement
 14 activities.

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

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

23 “(i) QUALITY.—For the performance
 24 category described in subparagraph (A)(i),
 25 the quality measures included in the final

measures list published under subparagraph (D)(i) for such year and the list of quality measures described in subparagraph (D)(vi) used by qualified clinical data registries under subsection (m)(3)(E).

“(ii) RESOURCE USE.—For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r) as appropriate, and, as feasible and applicable, accounting for the cost of drugs under part D.

“(iii) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

“(I) The subcategory of expanded practice access, such as same day appointments for urgent needs and after hours access to clinician advice.

1 “(II) The subcategory of popu-
2 lation management, such as moni-
3 toring health conditions of individuals
4 to provide timely health care interven-
5 tions or participation in a qualified
6 clinical data registry.

7 “(III) The subcategory of care
8 coordination, such as timely commu-
9 nication of test results, timely ex-
10 change of clinical information to pa-
11 tients and other providers, and use of
12 remote monitoring or telehealth.

13 “(IV) The subcategory of bene-
14 ficiary engagement, such as the estab-
15 lishment of care plans for individuals
16 with complex care needs, beneficiary
17 self-management assessment and
18 training, and using shared decision-
19 making mechanisms.

20 “(V) The subcategory of patient
21 safety and practice assessment, such
22 as through use of clinical or surgical
23 checklists and practice assessments
24 related to maintaining certification.

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

5 In establishing activities under this clause,
6 the Secretary shall give consideration to
7 the circumstances of small practices (con-
8 sisting of 15 or fewer professionals) and
9 practices located in rural areas and in
10 health professional shortage areas (as des-
11 ignated under section 332(a)(1)(A) of the
12 Public Health Service Act).

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

19 “(C) ADDITIONAL PROVISIONS.—

20 “(i) EMPHASIZING OUTCOME MEAS-
21 URES UNDER THE QUALITY PERFORMANCE
22 CATEGORY.—In applying subparagraph
23 (B)(i), the Secretary shall, as feasible, em-
24 phasize the application of outcome meas-
25 ures.

1 “(ii) APPLICATION OF ADDITIONAL
2 SYSTEM MEASURES.—The Secretary may
3 use measures used for a payment system
4 other than for physicians, such as meas-
5 ures for inpatient hospitals, for purposes of
6 the performance categories described in
7 clauses (i) and (ii) of subparagraph (A).
8 For purposes of the previous sentence, the
9 Secretary may not use measures for hos-
10 pital outpatient departments, except in the
11 case of items and services furnished by
12 emergency physicians, radiologists, and an-
13 esthesiologists.

14 “(iii) GLOBAL AND POPULATION-
15 BASED MEASURES.—The Secretary may
16 use global measures, such as global out-
17 come measures, and population-based
18 measures for purposes of the performance
19 category described in subparagraph (A)(i).

20 “(iv) APPLICATION OF MEASURES AND
21 ACTIVITIES TO NON-PATIENT-FACING PRO-
22 FESSIONALS.—In carrying out this para-
23 graph, with respect to measures and activi-
24 ties specified in subparagraph (B) for per-

1 performance categories described in subpara-
2 graph (A), the Secretary—

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

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

19 In carrying out the previous sentence, the
20 Secretary shall consult with professionals
21 of such professional types or subcategories.

22 “(v) CLINICAL PRACTICE IMPROVE-
23 MENT ACTIVITIES.—

24 “(I) REQUEST FOR INFORMA-
25 TION.—In initially applying subpara-

graph (B)(iii), the Secretary shall use a request for information to solicit recommendations from stakeholders to identify activities described in such subparagraph and specifying criteria for such activities.

“(II) CONTRACT AUTHORITY FOR CLINICAL PRACTICE IMPROVEMENT ACTIVITIES PERFORMANCE CATEGORY.—In applying subparagraph (B)(iii), the Secretary may contract with entities to assist the Secretary in—

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

“(bb) specifying criteria for such activities; and

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

“(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES DEFINED.—For purposes of this subsection, the term ‘clinical practice improvement

1 activity’ means an activity that rel-
2 evant eligible professional organiza-
3 tions and other relevant stakeholders
4 identify as improving clinical practice
5 or care delivery and that the Sec-
6 retary determines, when effectively ex-
7 ecuted, is likely to result in improved
8 outcomes.

9 “(D) ANNUAL LIST OF QUALITY MEASURES
10 AVAILABLE FOR MIPS ASSESSMENT.—

11 “(i) IN GENERAL.—Under the MIPS,
12 the Secretary, through notice and comment
13 rulemaking and subject to the succeeding
14 clauses of this subparagraph, shall, with
15 respect to the performance period for a
16 year, establish an annual final list of qual-
17 ity measures from which MIPS eligible
18 professionals may choose for purposes of
19 assessment under this subsection for such
20 performance period. Pursuant to the pre-
21 vious sentence, the Secretary shall—

22 “(I) not later than November 1
23 of the year prior to the first day of
24 the first performance period under the
25 MIPS, establish and publish in the

1 Federal Register a final list of quality
2 measures; and

3 “(II) not later than November 1
4 of the year prior to the first day of
5 each subsequent performance period,
6 update the final list of quality meas-
7 ures from the previous year (and pub-
8 lish such updated final list in the Fed-
9 eral Register), by—

10 “(aa) removing from such
11 list, as appropriate, quality meas-
12 ures, which may include the re-
13 moval of measures that are no
14 longer meaningful (such as meas-
15 ures that are topped out);

16 “(bb) adding to such list, as
17 appropriate, new quality meas-
18 ures; and

19 “(cc) determining whether
20 or not quality measures on such
21 list that have undergone sub-
22 stantive changes should be in-
23 cluded in the updated list.

24 “(ii) CALL FOR QUALITY MEAS-
25 URES.—

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

16 “(II) ELIGIBLE PROFESSIONAL
17 ORGANIZATION DEFINED.—In this
18 subparagraph, the term ‘eligible pro-
19 fessional organization’ means a pro-
20 fessional organization as defined by
21 nationally recognized specialty boards
22 of certification or equivalent certifi-
23 cation boards.

24 “(iii) REQUIREMENTS.—In selecting
25 quality measures for inclusion in the an-

1 nual final list under clause (i), the Sec-
2 retary shall—

3 “(I) provide that, to the extent
4 practicable, all quality domains (as
5 defined in subsection (s)(1)(B)) are
6 addressed by such measures; and

7 “(II) ensure that such selection
8 is consistent with the process for se-
9 lection of measures under subsections
10 (k), (m), and (p)(2).

11 “(iv) PEER REVIEW.—Before includ-
12 ing a new measure in the final list of
13 measures published under clause (i) for a
14 year, the Secretary shall submit for publi-
15 cation in applicable specialty-appropriate,
16 peer-reviewed journals such measure and
17 the method for developing and selecting
18 such measure, including clinical and other
19 data supporting such measure.

20 “(v) MEASURES FOR INCLUSION.—
21 The final list of quality measures published
22 under clause (i) shall include, as applica-
23 ble, measures under subsections (k), (m),
24 and (p)(2), including quality measures
25 from among—

- 1 “(I) measures endorsed by a con-
 2 sensus-based entity;
 3 “(II) measures developed under
 4 subsection (s); and
 5 “(III) measures submitted under
 6 clause (ii)(I).

7 Any measure selected for inclusion in such
 8 list that is not endorsed by a consensus-
 9 based entity shall have a focus that is evi-
 10 dence-based.

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

21 “(vii) EXCEPTION FOR EXISTING
 22 QUALITY MEASURES.—Any quality meas-
 23 ure specified by the Secretary under sub-
 24 section (k) or (m), including under sub-
 25 section (m)(3)(E), and any measure of

1 quality of care established under sub-
 2 section (p)(2) for the reporting period or
 3 performance period under the respective
 4 subsection beginning before the first per-
 5 formance period under the MIPS—

6 “(I) shall not be subject to the
 7 requirements under clause (i) (except
 8 under items (aa) and (cc) of subclause
 9 (II) of such clause) or to the require-
 10 ment under clause (iv); and

11 “(II) shall be included in the
 12 final list of quality measures pub-
 13 lished under clause (i) unless removed
 14 under clause (i)(II)(aa).

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

23 “(ix) OPTIONAL APPLICATION.—The
 24 process under section 1890A is not re-

1 quired to apply to the selection of meas-
2 ures under this subparagraph.

3 “(3) PERFORMANCE STANDARDS.—

4 “(A) ESTABLISHMENT.—Under the MIPS,
5 the Secretary shall establish performance stand-
6 ards with respect to measures and activities
7 specified under paragraph (2)(B) for a perform-
8 ance period (as established under paragraph
9 (4)) for a year.

10 “(B) CONSIDERATIONS IN ESTABLISHING
11 STANDARDS.—In establishing such performance
12 standards with respect to measures and activi-
13 ties specified under paragraph (2)(B), the Sec-
14 retary shall consider the following:

15 “(i) Historical performance standards.

16 “(ii) Improvement.

17 “(iii) The opportunity for continued
18 improvement.

19 “(4) PERFORMANCE PERIOD.—The Secretary
20 shall establish a performance period (or periods) for
21 a year (beginning with 2019). Such performance pe-
22 riod (or periods) shall begin and end prior to the be-
23 ginning of such year and be as close as possible to
24 such year. In this subsection, such performance pe-

1 riod (or periods) for a year shall be referred to as
2 the performance period for the year.

3 “(5) COMPOSITE PERFORMANCE SCORE.—

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

1 “(B) INCENTIVE TO REPORT; ENCOUR-
2 AGING USE OF CERTIFIED EHR TECHNOLOGY
3 FOR REPORTING QUALITY MEASURES.—

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

14 “(ii) ENCOURAGING USE OF CER-
15 TIFIED EHR TECHNOLOGY AND QUALIFIED
16 CLINICAL DATA REGISTRIES FOR REPORT-
17 ING QUALITY MEASURES.—Under the
18 methodology established under subpara-
19 graph (A), the Secretary shall—

20 “(I) encourage MIPS eligible
21 professionals to report on applicable
22 measures with respect to the perform-
23 ance category described in paragraph
24 (2)(A)(i) through the use of certified

1 EHR technology and qualified clinical
2 data registries; and

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

12 “(C) CLINICAL PRACTICE IMPROVEMENT
13 ACTIVITIES PERFORMANCE SCORE.—

14 “(i) RULE FOR CERTIFICATION.—A
15 MIPS eligible professional who is in a
16 practice that is certified as a patient-cen-
17 tered medical home or comparable spe-
18 cialty practice, as determined by the Sec-
19 retary, with respect to a performance pe-
20 riod shall be given the highest potential
21 score for the performance category de-
22 scribed in paragraph (2)(A)(iii) for such
23 period.

24 “(ii) APM PARTICIPATION.—Partici-
25 pation by a MIPS eligible professional in

1 an alternative payment model (as defined
 2 in section 1833(z)(3)(C)) with respect to a
 3 performance period shall earn such eligible
 4 professional a minimum score of one-half
 5 of the highest potential score for the per-
 6 formance category described in paragraph
 7 (2)(A)(iii) for such performance period.

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

16 “(D) ACHIEVEMENT AND IMPROVE-
 17 MENT.—

18 “(i) TAKING INTO ACCOUNT IMPROVE-
 19 MENT.—Beginning with the second year to
 20 which the MIPS applies, in addition to the
 21 achievement of a MIPS eligible profes-
 22 sional, if data sufficient to measure im-
 23 provement is available, the methodology
 24 developed under subparagraph (A)—

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

7 “(II) in the case of performance
8 scores for other performance cat-
9 egories, may take into account the im-
10 provement of the professional.

11 “(ii) ASSIGNING HIGHER WEIGHT FOR
12 ACHIEVEMENT.—Subject to clause (i),
13 under the methodology developed under
14 subparagraph (A), the Secretary may as-
15 sign a higher scoring weight under sub-
16 paragraph (F) with respect to the achieve-
17 ment of a MIPS eligible professional than
18 with respect to any improvement of such
19 professional applied under clause (i) with
20 respect to a measure, activity, or category
21 described in paragraph (2).

22 “(E) WEIGHTS FOR THE PERFORMANCE
23 CATEGORIES.—

24 “(i) IN GENERAL.—Under the meth-
25 odology developed under subparagraph (A),

1 subject to subparagraph (F)(i) and clause
2 (ii), the composite performance score shall
3 be determined as follows:

4 “(I) QUALITY.—

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

15 “(bb) FIRST 2 YEARS.—For
16 the first and second years for
17 which the MIPS applies to pay-
18 ments, the percentage applicable
19 under item (aa) shall be in-
20 creased in a manner such that
21 the total percentage points of the
22 increase under this item for the
23 respective year equals the total
24 number of percentage points by
25 which the percentage applied

1 under subclause (II)(bb) for the
2 respective year is less than 30
3 percent.

4 “(II) RESOURCE USE.—

5 “(aa) IN GENERAL.—Sub-
6 ject to item (bb), thirty percent
7 of such score shall be based on
8 performance with respect to the
9 category described in clause (ii)
10 of paragraph (2)(A).

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

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

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

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

centages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

“(F) CERTAIN FLEXIBILITY FOR WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES.—Under the methodology under subparagraph (A), if there are not sufficient measures and activities (described in paragraph (2)(B)) applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0)—

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

“(ii) for each measure and activity specified under paragraph (2)(B) with re-

1 spect to each such category based on the
2 extent to which the measure or activity is
3 applicable and available to the type of eli-
4 gible professional involved.

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

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

20 “(I) USE OF VOLUNTARY VIRTUAL GROUPS
21 FOR CERTAIN ASSESSMENT PURPOSES.—

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

1 purposes of applying the methodology
2 under subparagraph (A) with respect to
3 the performance categories described in
4 clauses (i) and (ii) of paragraph (2)(A)—

5 “(I) the assessment of perform-
6 ance provided under such methodology
7 with respect to such performance cat-
8 egories that is to be applied to each
9 such professional in such group for
10 such performance period shall be with
11 respect to the combined performance
12 of all such professionals in such group
13 for such period; and

14 “(II) with respect to the com-
15 posite performance score provided
16 under this paragraph for such per-
17 formance period for each such MIPS
18 eligible professional in such virtual
19 group, the components of the com-
20 posite performance score that assess
21 performance with respect to such per-
22 formance categories shall be based on
23 the assessment of the combined per-
24 formance under subclause (I) for such

1 performance categories and perform-
2 ance period.

3 “(ii) ELECTION OF PRACTICES TO BE
4 A VIRTUAL GROUP.—The Secretary shall,
5 in accordance with the requirements under
6 clause (iii), establish and have in place a
7 process to allow an individual MIPS eligi-
8 ble professional or a group practice con-
9 sisting of not more than 10 MIPS eligible
10 professionals to elect, with respect to a
11 performance period for a year to be a vir-
12 tual group under this subparagraph with
13 at least one other such individual MIPS el-
14 igible professional or group practice. Such
15 a virtual group may be based on appro-
16 priate classifications of providers, such as
17 by geographic areas or by provider special-
18 ties defined by nationally recognized spe-
19 cialty boards of certification or equivalent
20 certification boards.

21 “(iii) REQUIREMENTS.—The require-
22 ments for the process under clause (ii)
23 shall—

24 “(I) provide that an election
25 under such clause, with respect to a

1 performance period, shall be made be-
2 fore the beginning of such perform-
3 ance period and may not be changed
4 during such performance period;

5 “(II) provide that an individual
6 MIPS eligible professional and a
7 group practice described in clause (ii)
8 may elect to be in no more than one
9 virtual group for a performance period
10 and that, in the case of such a group
11 practice that elects to be in such vir-
12 tual group for such performance pe-
13 riod, such election applies to all MIPS
14 eligible professionals in such group
15 practice;

16 “(III) provide that a virtual
17 group be a combination of tax identi-
18 fication numbers;

19 “(IV) provide for formal written
20 agreements among MIPS eligible pro-
21 fessionals electing to be a virtual
22 group under this subparagraph; and

23 “(V) include such other require-
24 ments as the Secretary determines ap-
25 propriate.

1 “(6) MIPS PAYMENTS.—

2 “(A) MIPS ADJUSTMENT FACTOR.—Tak-
3 ing into account paragraph (1)(G), the Sec-
4 retary shall specify a MIPS adjustment factor
5 for each MIPS eligible professional for a year.
6 Such MIPS adjustment factor for a MIPS eligi-
7 ble professional for a year shall be in the form
8 of a percent and shall be determined—

9 “(i) by comparing the composite per-
10 formance score of the eligible professional
11 for such year to the performance threshold
12 established under subparagraph (D)(i) for
13 such year;

14 “(ii) in a manner such that the ad-
15 justment factors specified under this sub-
16 paragraph for a year result in differential
17 payments under this paragraph reflecting
18 that—

19 “(I) MIPS eligible professionals
20 with composite performance scores for
21 such year at or above such perform-
22 ance threshold for such year receive
23 zero or positive payment adjustment
24 factors for such year in accordance
25 with clause (iii), with such profes-

sionals having higher composite performance scores receiving higher adjustment factors; and

“(II) MIPS eligible professionals with composite performance scores for such year below such performance threshold for such year receive negative payment adjustment factors for such year in accordance with clause (iv), with such professionals having lower composite performance scores receiving lower adjustment factors;

“(iii) in a manner such that MIPS eligible professionals with composite scores described in clause (ii)(I) for such year, subject to clauses (i) and (ii) of subparagraph (F), receive a zero or positive adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the applicable percent specified in subparagraph (B) is assigned for a score of 100; and

“(iv) in a manner such that—

1 “(I) subject to subclause (II),
2 MIPS eligible professionals with com-
3 posite performance scores described in
4 clause (ii)(II) for such year receive a
5 negative payment adjustment factor
6 on a linear sliding scale such that an
7 adjustment factor of 0 percent is as-
8 signed for a score at the performance
9 threshold and an adjustment factor of
10 the negative of the applicable percent
11 specified in subparagraph (B) is as-
12 signed for a score of 0; and

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

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

1 “(i) for 2019, 4 percent;
2 “(ii) for 2020, 5 percent;
3 “(iii) for 2021, 7 percent; and
4 “(iv) for 2022 and subsequent years,
5 9 percent.

6 “(C) ADDITIONAL MIPS ADJUSTMENT FAC-
7 TORS FOR EXCEPTIONAL PERFORMANCE.—For
8 2019 and each subsequent year through 2024,
9 in the case of a MIPS eligible professional with
10 a composite performance score for a year at or
11 above the additional performance threshold
12 under subparagraph (D)(ii) for such year, in
13 addition to the MIPS adjustment factor under
14 subparagraph (A) for the eligible professional
15 for such year, subject to subparagraph (F)(iv),
16 the Secretary shall specify an additional positive
17 MIPS adjustment factor for such professional
18 and year. Such additional MIPS adjustment
19 factors shall be in the form of a percent and de-
20 termined by the Secretary in a manner such
21 that professionals having higher composite per-
22 formance scores above the additional perform-
23 ance threshold receive higher additional MIPS
24 adjustment factors.

“(D) ESTABLISHMENT OF PERFORMANCE

THRESHOLDS.—

“(i) PERFORMANCE THRESHOLD.—

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

“(ii) ADDITIONAL PERFORMANCE

THRESHOLD FOR EXCEPTIONAL PERFORMANCE.—In addition to the performance threshold under clause (i), for each year of the MIPS, the Secretary shall compute an additional performance threshold for pur-

1 poses of determining the additional MIPS
2 adjustment factors under subparagraph
3 (C). For each such year, the Secretary
4 shall apply either of the following methods
5 for computing such additional performance
6 threshold for such a year:

7 “(I) The threshold shall be the
8 score that is equal to the 25th per-
9 centile of the range of possible com-
10 posite performance scores above the
11 performance threshold determined
12 under clause (i).

13 “(II) The threshold shall be the
14 score that is equal to the 25th per-
15 centile of the actual composite per-
16 formance scores for MIPS eligible
17 professionals with composite perform-
18 ance scores at or above the perform-
19 ance threshold with respect to the
20 prior period described in clause (i).

21 “(iii) SPECIAL RULE FOR INITIAL 2
22 YEARS.—With respect to each of the first
23 two years to which the MIPS applies, the
24 Secretary shall, prior to the performance
25 period for such years, establish a perform-

1 ance threshold for purposes of determining
 2 MIPS adjustment factors under subpara-
 3 graph (A) and a threshold for purposes of
 4 determining additional MIPS adjustment
 5 factors under subparagraph (C). Each
 6 such performance threshold shall—

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

9 “(II) take into account—

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

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

19 “(E) APPLICATION OF MIPS ADJUSTMENT
 20 FACTORS.—In the case of items and services
 21 furnished by a MIPS eligible professional dur-
 22 ing a year (beginning with 2019), the amount
 23 otherwise paid under this part with respect to
 24 such items and services and MIPS eligible pro-
 25 fessional for such year, shall be multiplied by—

1 “(i) 1, plus

2 “(ii) the sum of—

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

6 “(II) as applicable, the additional
7 MIPS adjustment factor determined
8 under subparagraph (C) divided by
9 100.

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

12 “(i) APPLICATION OF SCALING FAC-
13 TOR.—

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

1 “(II) SCALING FACTOR LIMIT.—

2 In no case may the scaling factor ap-
3 plied under this clause exceed 3.0.

4 “(ii) BUDGET NEUTRALITY REQUIRE-
5 MENT.—

6 “(I) IN GENERAL.—Subject to
7 clause (iii), the Secretary shall ensure
8 that the estimated amount described
9 in subclause (II) for a year is equal to
10 the estimated amount described in
11 subclause (III) for such year.

12 “(II) AGGREGATE INCREASES.—
13 The amount described in this sub-
14 clause is the estimated increase in the
15 aggregate allowed charges resulting
16 from the application of positive MIPS
17 adjustment factors under subpara-
18 graph (A) (after application of the
19 scaling factor described in clause (i))
20 to MIPS eligible professionals whose
21 composite performance score for a
22 year is above the performance thresh-
23 old under subparagraph (D)(i) for
24 such year.

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

12 “(iii) EXCEPTIONS.—

13 “(I) In the case that all MIPS el-
14 igible professionals receive composite
15 performance scores for a year that are
16 below the performance threshold
17 under subparagraph (D)(i) for such
18 year, the negative MIPS adjustment
19 factors under subparagraph (A) shall
20 apply with respect to such MIPS eligi-
21 ble professionals and the budget neu-
22 trality requirement of clause (ii) and
23 the additional adjustment factors
24 under clause (iv) shall not apply for
25 such year.

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

9 “(iv) ADDITIONAL INCENTIVE PAY-
10 MENT ADJUSTMENTS.—

11 “(I) IN GENERAL.—Subject to
12 subclause (II), in specifying the MIPS
13 additional adjustment factors under
14 subparagraph (C) for each applicable
15 MIPS eligible professional for a year,
16 the Secretary shall ensure that the es-
17 timated aggregate increase in pay-
18 ments under this part resulting from
19 the application of such additional ad-
20 justment factors for MIPS eligible
21 professionals in a year shall be equal
22 (as estimated by the Secretary) to
23 \$500,000,000 for each year beginning
24 with 2019 and ending with 2024.

1 “(II) LIMITATION ON ADDI-
2 TIONAL INCENTIVE PAYMENT ADJUST-
3 MENTS.—The MIPS additional ad-
4 justment factor under subparagraph
5 (C) for a year for an applicable MIPS
6 eligible professional whose composite
7 performance score is above the addi-
8 tional performance threshold under
9 subparagraph (D)(ii) for such year
10 shall not exceed 10 percent. The ap-
11 plication of the previous sentence may
12 result in an aggregate amount of ad-
13 ditional incentive payments that are
14 less than the amount specified in sub-
15 clause (I).

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

1 mation in the confidential feedback under paragraph
2 (12).

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

10 “(9) PUBLIC REPORTING.—

11 “(A) IN GENERAL.—The Secretary shall,
12 in an easily understandable format, make avail-
13 able on the Physician Compare Internet website
14 of the Centers for Medicare & Medicaid Serv-
15 ices the following:

16 “(i) Information regarding the per-
17 formance of MIPS eligible professionals
18 under the MIPS, which—

19 “(I) shall include the composite
20 score for each such MIPS eligible pro-
21 fessional and the performance of each
22 such MIPS eligible professional with
23 respect to each performance category;
24 and

1 “(II) may include the perform-
2 ance of each such MIPS eligible pro-
3 fessional with respect to each measure
4 or activity specified in paragraph
5 (2)(B).

6 “(ii) The names of eligible profes-
7 sionals in eligible alternative payment mod-
8 els (as defined in section 1833(z)(3)(D))
9 and, to the extent feasible, the names of
10 such eligible alternative payment models
11 and performance of such models.

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

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

1 such subparagraph prior to such information
2 being made public.

3 “(D) AGGREGATE INFORMATION.—The
4 Secretary shall periodically post on the Physi-
5 cian Compare Internet website aggregate infor-
6 mation on the MIPS, including the range of
7 composite scores for all MIPS eligible profes-
8 sionals and the range of the performance of all
9 MIPS eligible professionals with respect to each
10 performance category.

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

20 “(11) TECHNICAL ASSISTANCE TO SMALL PRAC-
21 TICES AND PRACTICES IN HEALTH PROFESSIONAL
22 SHORTAGE AREAS.—

23 “(A) IN GENERAL.—The Secretary shall
24 enter into contracts or agreements with appro-
25 priate entities (such as quality improvement or-

ganizations, regional extension centers (as described in section 3012(c) of the Public Health Service Act), or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of such Act), and medically underserved areas, and practices with low composite scores) with respect to—

“(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or

“(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1833(z)(3)(C).

“(B) FUNDING FOR TECHNICAL ASSISTANCE.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Ac-

count of \$20,000,000 for each of fiscal years 2016 through 2020. Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

“(12) FEEDBACK AND INFORMATION TO IMPROVE PERFORMANCE.—

“(A) PERFORMANCE FEEDBACK.—

“(i) IN GENERAL.—Beginning July 1, 2017, the Secretary—

“(I) shall make available timely (such as quarterly) confidential feedback to MIPS eligible professionals on the performance of such professionals with respect to the performance categories under clauses (i) and (ii) of paragraph (2)(A); and

“(II) may make available confidential feedback to such professionals on the performance of such professionals with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

“(ii) MECHANISMS.—The Secretary may use one or more mechanisms to make feedback available under clause (i), which

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

18 “(iii) USE OF DATA.—For purposes of
19 clause (i), the Secretary may use data,
20 with respect to a MIPS eligible profes-
21 sional, from periods prior to the current
22 performance period and may use rolling
23 periods in order to make illustrative cal-
24 culations about the performance of such
25 professional.

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

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

11 “(B) ADDITIONAL INFORMATION.—

12 “(i) IN GENERAL.—Beginning July 1,
13 2018, the Secretary shall make available to
14 MIPS eligible professionals information,
15 with respect to individuals who are pa-
16 tients of such MIPS eligible professionals,
17 about items and services for which pay-
18 ment is made under this title that are fur-
19 nished to such individuals by other sup-
20 pliers and providers of services, which may
21 include information described in clause (ii).
22 Such information may be made available
23 under the previous sentence to such MIPS
24 eligible professionals by mechanisms deter-
25 mined appropriate by the Secretary, which

1 may include use of a web-based portal.
2 Such information may be made available in
3 accordance with the same or similar terms
4 as data are made available to accountable
5 care organizations participating in the
6 shared savings program under section
7 1899.

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

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

1 ices so furnished, and the dates such
2 items and services were so furnished.

3 “(II) Historical data, such as
4 averages and other measures of the
5 distribution if appropriate, of the
6 total, and components of, allowed
7 charges (and other figures as deter-
8 mined appropriate by the Secretary).

9 “(13) REVIEW.—

10 “(A) TARGETED REVIEW.—The Secretary
11 shall establish a process under which a MIPS
12 eligible professional may seek an informal re-
13 view of the calculation of the MIPS adjustment
14 factor (or factors) applicable to such eligible
15 professional under this subsection for a year.
16 The results of a review conducted pursuant to
17 the previous sentence shall not be taken into ac-
18 count for purposes of paragraph (6) with re-
19 spect to a year (other than with respect to the
20 calculation of such eligible professional’s MIPS
21 adjustment factor for such year or additional
22 MIPS adjustment factor for such year) after
23 the factors determined in subparagraph (A) and
24 subparagraph (C) of such paragraph have been
25 determined for such year.

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

5 “(i) The methodology used to deter-
6 mine the amount of the MIPS adjustment
7 factor under paragraph (6)(A) and the
8 amount of the additional MIPS adjustment
9 factor under paragraph (6)(C) and the de-
10 termination of such amounts.

11 “(ii) The establishment of the per-
12 formance standards under paragraph (3)
13 and the performance period under para-
14 graph (4).

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

21 “(iv) The methodology developed
22 under paragraph (5) that is used to cal-
23 culate performance scores and the calcula-
24 tion of such scores, including the weighting

1 of measures and activities under such
2 methodology.”.

3 (2) GAO REPORTS.—

4 (A) EVALUATION OF ELIGIBLE PROFES-
5 SIONAL MIPS.—Not later than October 1, 2021,
6 the Comptroller General of the United States
7 shall submit to Congress a report evaluating the
8 eligible professional Merit-based Incentive Pay-
9 ment System under subsection (q) of section
10 1848 of the Social Security Act (42 U.S.C.
11 1395w–4), as added by paragraph (1). Such re-
12 port shall—

13 (i) examine the distribution of the
14 composite performance scores and MIPS
15 adjustment factors (and additional MIPS
16 adjustment factors) for MIPS eligible pro-
17 fessionals (as defined in subsection
18 (q)(1)(c) of such section) under such pro-
19 gram, and patterns relating to such scores
20 and adjustment factors, including based on
21 type of provider, practice size, geographic
22 location, and patient mix;

23 (ii) provide recommendations for im-
24 proving such program;

(iii) evaluate the impact of technical assistance funding under section 1848(q)(11) of the Social Security Act, as added by paragraph (1), on the ability of professionals to improve within such program or successfully transition to an alternative payment model (as defined in section 1833(z)(3) of the Social Security Act, as added by subsection (e)), with priority for such evaluation given to practices located in rural areas, health professional shortage areas (as designated in section 332(a)(1)(A) of the Public Health Service Act), and medically underserved areas; and

(iv) provide recommendations for optimizing the use of such technical assistance funds.

(B) STUDY TO EXAMINE ALIGNMENT OF QUALITY MEASURES USED IN PUBLIC AND PRIVATE PROGRAMS.—

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

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

11 (II) makes recommendations on
12 how to reduce the administrative bur-
13 den involved in applying such quality
14 measures.

15 (ii) REQUIREMENTS.—The report
16 under clause (i) shall—

17 (I) consider those measures ap-
18 plicable to individuals entitled to, or
19 enrolled for, benefits under such part
20 A, or enrolled under such part B and
21 individuals under the age of 65; and

22 (II) focus on those measures that
23 comprise the most significant compo-
24 nent of the quality performance cat-
25 egory of the eligible professional

1 MIPS incentive program under sub-
2 section (q) of section 1848 of the So-
3 cial Security Act (42 U.S.C. 1395w-
4 4), as added by paragraph (1).

5 (C) STUDY ON ROLE OF INDEPENDENT
6 RISK MANAGERS.—Not later than January 1,
7 2017, the Comptroller General of the United
8 States shall submit to Congress a report exam-
9 ining whether entities that pool financial risk
10 for physician practices, such as independent
11 risk managers, can play a role in supporting
12 physician practices, particularly small physician
13 practices, in assuming financial risk for the
14 treatment of patients. Such report shall exam-
15 ine barriers that small physician practices cur-
16 rently face in assuming financial risk for treat-
17 ing patients, the types of risk management enti-
18 ties that could assist physician practices in par-
19 ticipating in two-sided risk payment models,
20 and how such entities could assist with risk
21 management and with quality improvement ac-
22 tivities. Such report shall also include an anal-
23 ysis of any existing legal barriers to such ar-
24 rangements.

1 (D) STUDY TO EXAMINE RURAL AND
2 HEALTH PROFESSIONAL SHORTAGE AREA AL-
3 TERNATIVE PAYMENT MODELS.—Not later than
4 October 1, 2021, the Comptroller General of
5 the United States shall submit to Congress a
6 report that examines the transition of profes-
7 sionals in rural areas, health professional short-
8 age areas (as designated in section
9 332(a)(1)(A) of the Public Health Service Act),
10 or medically underserved areas to an alternative
11 payment model (as defined in section
12 1833(z)(3) of the Social Security Act, as added
13 by subsection (e)). Such report shall make rec-
14 ommendations for removing administrative bar-
15 riers to practices, including small practices con-
16 sisting of 15 or fewer professionals, in rural
17 areas, health professional shortage areas, and
18 medically underserved areas to participation in
19 such models.

20 (3) FUNDING FOR IMPLEMENTATION.—For
21 purposes of implementing the provisions of and the
22 amendments made by this section, the Secretary of
23 Health and Human Services shall provide for the
24 transfer of \$80,000,000 from the Supplementary
25 Medical Insurance Trust Fund established under

1 section 1841 of the Social Security Act (42 U.S.C.
 2 1395t) to the Centers for Medicare & Medicaid Pro-
 3 gram Management Account for each of the fiscal
 4 years 2015 through 2019. Amounts transferred
 5 under this paragraph shall be available until ex-
 6 pended.

7 (d) IMPROVING QUALITY REPORTING FOR COM-
 8 POSITE SCORES.—

9 (1) CHANGES FOR GROUP REPORTING OP-
 10 TION.—

11 (A) IN GENERAL.—Section
 12 1848(m)(3)(C)(ii) of the Social Security Act
 13 (42 U.S.C. 1395w–4(m)(3)(C)(ii)) is amended
 14 by inserting “and, for 2016 and subsequent
 15 years, may provide” after “shall provide”.

16 (B) CLARIFICATION OF QUALIFIED CLIN-
 17 ICAL DATA REGISTRY REPORTING TO GROUP
 18 PRACTICES.—Section 1848(m)(3)(D) of the So-
 19 cial Security Act (42 U.S.C. 1395w–
 20 4(m)(3)(D)) is amended by inserting “and, for
 21 2016 and subsequent years, subparagraph (A)
 22 or (C)” after “subparagraph (A)”.

23 (2) CHANGES FOR MULTIPLE REPORTING PERI-
 24 ODS AND ALTERNATIVE CRITERIA FOR SATISFAC-
 25 TORY REPORTING.—Section 1848(m)(5)(F) of the

1 Social Security Act (42 U.S.C. 1395w–4(m)(5)(F))
2 is amended—

3 (A) by striking “and subsequent years”
4 and inserting “through reporting periods occur-
5 ring in 2015”; and

6 (B) by inserting “and, for reporting peri-
7 ods occurring in 2016 and subsequent years,
8 the Secretary may establish” after “shall estab-
9 lish”.

10 (3) PHYSICIAN FEEDBACK PROGRAM REPORTS
11 SUCCEEDED BY REPORTS UNDER MIPS.—Section
12 1848(n) of the Social Security Act (42 U.S.C.
13 1395w–4(n)) is amended by adding at the end the
14 following new paragraph:

15 “(11) REPORTS ENDING WITH 2017.—Reports
16 under the Program shall not be provided after De-
17 cember 31, 2017. See subsection (q)(12) for reports
18 under the eligible professionals Merit-based Incentive
19 Payment System.”.

20 (4) COORDINATION WITH SATISFYING MEANING-
21 FUL EHR USE CLINICAL QUALITY MEASURE REPORT-
22 ING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of
23 the Social Security Act (42 U.S.C. 1395w–
24 4(o)(2)(A)(iii)) is amended by inserting “and sub-

section (q)(5)(B)(ii)(II)” after “Subject to subparagraph (B)(ii)”.

(e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

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

“(c) PHYSICIAN-FOCUSED PAYMENT MODELS.—

“(1) TECHNICAL ADVISORY COMMITTEE.—

“(A) ESTABLISHMENT.—There is established an ad hoc committee to be known as the ‘Physician-Focused Payment Model Technical Advisory Committee’ (referred to in this subsection as the ‘Committee’).

“(B) MEMBERSHIP.—

“(i) NUMBER AND APPOINTMENT.—

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

“(ii) QUALIFICATIONS.—The membership of the Committee shall include individuals with national recognition for their expertise in physician-focused payment models and related delivery of care. No more than 5 members of the Committee

1 shall be providers of services or suppliers,
2 or representatives of providers of services
3 or suppliers.

4 “(iii) PROHIBITION ON FEDERAL EM-
5 PLOYMENT.—A member of the Committee
6 shall not be an employee of the Federal
7 Government.

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

18 “(v) DATE OF INITIAL APPOINT-
19 MENTS.—The initial appointments of mem-
20 bers of the Committee shall be made by
21 not later than 180 days after the date of
22 enactment of this subsection.

23 “(C) TERM; VACANCIES.—

24 “(i) TERM.—The terms of members of
25 the Committee shall be for 3 years except

1 that the Comptroller General shall des-
2 ignate staggered terms for the members
3 first appointed.

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

14 “(D) DUTIES.—The Committee shall meet,
15 as needed, to provide comments and rec-
16 ommendations to the Secretary, as described in
17 paragraph (2)(C), on physician-focused pay-
18 ment models.

19 “(E) COMPENSATION OF MEMBERS.—

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

23 “(ii) TRAVEL EXPENSES.—A member
24 of the Committee shall be allowed travel
25 expenses, including per diem in lieu of sub-

1 sistence, at rates authorized for an em-
2 ployee of an agency under subchapter I of
3 chapter 57 of title 5, United States Code,
4 while away from the home or regular place
5 of business of the member in the perform-
6 ance of the duties of the Committee.

7 “(F) OPERATIONAL AND TECHNICAL SUP-
8 PORT.—

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

17 “(ii) FUNDING.—The Secretary shall
18 provide for the transfer, from the Federal
19 Supplementary Medical Insurance Trust
20 Fund under section 1841, such amounts as
21 are necessary to carry out this paragraph
22 (not to exceed \$5,000,000) for fiscal year
23 2015 and each subsequent fiscal year. Any
24 amounts transferred under the preceding

1 sentence for a fiscal year shall remain
2 available until expended.

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

6 “(2) CRITERIA AND PROCESS FOR SUBMISSION
7 AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT
8 MODELS.—

9 “(A) CRITERIA FOR ASSESSING PHYSICIAN-
10 FOCUSED PAYMENT MODELS.—

11 “(i) RULEMAKING.—Not later than
12 November 1, 2016, the Secretary shall,
13 through notice and comment rulemaking,
14 following a request for information, estab-
15 lish criteria for physician-focused payment
16 models, including models for specialist phy-
17 sicians, that could be used by the Com-
18 mittee for making comments and rec-
19 ommendations pursuant to paragraph
20 (1)(D).

21 “(ii) MEDPAC SUBMISSION OF COM-
22 MENTS.—During the comment period for
23 the proposed rule described in clause (i),
24 the Medicare Payment Advisory Commis-
25 sion may submit comments to the Sec-

1 retary on the proposed criteria under such
2 clause.

3 “(iii) UPDATING.—The Secretary may
4 update the criteria established under this
5 subparagraph through rulemaking.

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

13 “(C) COMMITTEE REVIEW OF MODELS
14 SUBMITTED.—The Committee shall, on a peri-
15 odic basis, review models submitted under sub-
16 paragraph (B), prepare comments and rec-
17 ommendations regarding whether such models
18 meet the criteria described in subparagraph
19 (A), and submit such comments and rec-
20 ommendations to the Secretary.

21 “(D) SECRETARY REVIEW AND RE-
22 SPONSE.—The Secretary shall review the com-
23 ments and recommendations submitted by the
24 Committee under subparagraph (C) and post a
25 detailed response to such comments and rec-

1 ommendations on the Internet website of the
2 Centers for Medicare & Medicaid Services.

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

7 (2) INCENTIVE PAYMENTS FOR PARTICIPATION
8 IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—
9 Section 1833 of the Social Security Act (42 U.S.C.
10 1395l) is amended by adding at the end the fol-
11 lowing new subsection:

12 “(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN
13 ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

14 “(1) PAYMENT INCENTIVE.—

15 “(A) IN GENERAL.—In the case of covered
16 professional services furnished by an eligible
17 professional during a year that is in the period
18 beginning with 2019 and ending with 2024 and
19 for which the professional is a qualifying APM
20 participant with respect to such year, in addi-
21 tion to the amount of payment that would oth-
22 erwise be made for such covered professional
23 services under this part for such year, there
24 also shall be paid to such professional an
25 amount equal to 5 percent of the estimated ag-

1 aggregate payment amounts for such covered pro-
2 fessional services under this part for the pre-
3 ceding year. For purposes of the previous sen-
4 tence, the payment amount for the preceding
5 year may be an estimation for the full pre-
6 ceding year based on a period of such preceding
7 year that is less than the full year. The Sec-
8 retary shall establish policies to implement this
9 subparagraph in cases in which payment for
10 covered professional services furnished by a
11 qualifying APM participant in an alternative
12 payment model—

13 “(i) is made to an eligible alternative
14 payment entity rather than directly to the
15 qualifying APM participant; or

16 “(ii) is made on a basis other than a
17 fee-for-service basis (such as payment on a
18 capitated basis).

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 under this subsection or
6 subsection (m) shall be determined without re-
7 gard to any additional payment under sub-
8 section (m) and this subsection, respectively.
9 The amount of the additional payment under
10 this subsection or subsection (x) shall be deter-
11 mined without regard to any additional pay-
12 ment under subsection (x) and this subsection,
13 respectively. The amount of the additional pay-
14 ment under this subsection or subsection (y)
15 shall be determined without regard to any addi-
16 tional payment under subsection (y) and this
17 subsection, respectively.

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

21 “(A) 2019 AND 2020.—With respect to
22 2019 and 2020, an eligible professional for
23 whom the Secretary determines that at least 25
24 percent of payments under this part for covered
25 professional services furnished by such profes-

1 sional during the most recent period for which
2 data are available (which may be less than a
3 year) were attributable to such services fur-
4 nished under this part through an eligible alter-
5 native payment entity.

6 “(B) 2021 AND 2022.—With respect to
7 2021 and 2022, an eligible professional de-
8 scribed in either of the following clauses:

9 “(i) MEDICARE PAYMENT THRESHOLD
10 OPTION.—An eligible professional for
11 whom the Secretary determines that at
12 least 50 percent of payments under this
13 part for covered professional services fur-
14 nished by such professional during the
15 most recent period for which data are
16 available (which may be less than a year)
17 were attributable to such services furnished
18 under this part through an eligible alter-
19 native payment entity.

20 “(ii) COMBINATION ALL-PAYER AND
21 MEDICARE PAYMENT THRESHOLD OP-
22 TION.—An eligible professional—

23 “(I) for whom the Secretary de-
24 termines, with respect to items and
25 services furnished by such professional

1 during the most recent period for
2 which data are available (which may
3 be less than a year), that at least 50
4 percent of the sum of—

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

7 “(bb) all other payments, re-
8 gardless of payer (other than
9 payments made by the Secretary
10 of Defense or the Secretary of
11 Veterans Affairs and other than
12 payments made under title XIX
13 in a State in which no medical
14 home or alternative payment
15 model is available under the
16 State program under that title),
17 meet the requirement described in
18 clause (iii)(I) with respect to pay-
19 ments described in item (aa) and meet
20 the requirement described in clause
21 (iii)(II) with respect to payments de-
22 scribed in item (bb);

23 “(II) for whom the Secretary de-
24 termines at least 25 percent of pay-
25 ments under this part for covered pro-

1 professional services furnished by such
2 professional during the most recent
3 period for which data are available
4 (which may be less than a year) were
5 attributable to such services furnished
6 under this part through an eligible al-
7 ternative payment entity; and

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

13 “(iii) REQUIREMENT.—For purposes
14 of clause (ii)(I)—

15 “(I) the requirement described in
16 this subclause, with respect to pay-
17 ments described in item (aa) of such
18 clause, is that such payments are
19 made to an eligible alternative pay-
20 ment entity; and

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

1 “(aa) quality measures com-
2 parable to measures under the
3 performance category described
4 in section 1848(q)(2)(B)(i) apply;

5 “(bb) certified EHR tech-
6 nology is used; and

7 “(cc) the eligible profes-
8 sional participates in an entity
9 that—

10 “(AA) bears more than
11 nominal financial risk if ac-
12 tual aggregate expenditures
13 exceeds expected aggregate
14 expenditures; or

15 “(BB) with respect to
16 beneficiaries under title
17 XIX, is a medical home that
18 meets criteria comparable to
19 medical homes expanded
20 under section 1115A(c).

21 “(C) BEGINNING IN 2023.—With respect to
22 2023 and each subsequent year, an eligible pro-
23 fessional described in either of the following
24 clauses:

1 “(i) MEDICARE PAYMENT THRESHOLD
2 OPTION.—An eligible professional for
3 whom the Secretary determines that at
4 least 75 percent of payments under this
5 part for covered professional services fur-
6 nished by such professional during the
7 most recent period for which data are
8 available (which may be less than a year)
9 were attributable to such services furnished
10 under this part through an eligible alter-
11 native payment entity.

12 “(ii) COMBINATION ALL-PAYER AND
13 MEDICARE PAYMENT THRESHOLD OP-
14 TION.—An eligible professional—

15 “(I) for whom the Secretary de-
16 termines, with respect to items and
17 services furnished by such professional
18 during the most recent period for
19 which data are available (which may
20 be less than a year), that at least 75
21 percent of the sum of—

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

24 “(bb) all other payments, re-
25 gardless of payer (other than

1 payments made by the Secretary
2 of Defense or the Secretary of
3 Veterans Affairs and other than
4 payments made under title XIX
5 in a State in which no medical
6 home or alternative payment
7 model is available under the
8 State program under that title),
9 meet the requirement described in
10 clause (iii)(I) with respect to pay-
11 ments described in item (aa) and meet
12 the requirement described in clause
13 (iii)(II) with respect to payments de-
14 scribed in item (bb);

15 “(II) for whom the Secretary de-
16 termines at least 25 percent of pay-
17 ments under this part for covered pro-
18 fessional services furnished by such
19 professional during the most recent
20 period for which data are available
21 (which may be less than a year) were
22 attributable to such services furnished
23 under this part through an eligible al-
24 ternative payment entity; and

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

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

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

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

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

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

1 “(cc) the eligible profes-
2 sional participates in an entity
3 that—

4 “(AA) bears more than
5 nominal financial risk if ac-
6 tual aggregate expenditures
7 exceeds expected aggregate
8 expenditures; or

9 “(BB) with respect to
10 beneficiaries under title
11 XIX, is a medical home that
12 meets criteria comparable to
13 medical homes expanded
14 under section 1115A(c).

15 “(D) USE OF PATIENT APPROACH.—The
16 Secretary may base the determination of wheth-
17 er an eligible professional is a qualifying APM
18 participant under this subsection and the deter-
19 mination of whether an eligible professional is a
20 partial qualifying APM participant under sec-
21 tion 1848(q)(1)(C)(iii) by using counts of pa-
22 tients in lieu of using payments and using the
23 same or similar percentage criteria (as specified
24 in this subsection and such section, respec-
25 tively), as the Secretary determines appropriate.

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

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

7 “(B) ELIGIBLE PROFESSIONAL.—The term
8 ‘eligible professional’ has the meaning given
9 that term in section 1848(k)(3)(B) and includes
10 a group that includes such professionals.

11 “(C) ALTERNATIVE PAYMENT MODEL
12 (APM).—The term ‘alternative payment model’
13 means, other than for purposes of subpara-
14 graphs (B)(ii)(I)(bb) and (C)(ii)(I)(bb) of para-
15 graph (2), any of the following:

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

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

21 “(iii) A demonstration under section
22 1866C.

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

1 “(D) ELIGIBLE ALTERNATIVE PAYMENT
2 ENTITY.—The term ‘eligible alternative pay-
3 ment entity’ means, with respect to a year, an
4 entity that—

5 “(i) participates in an alternative pay-
6 ment model that—

7 “(I) requires participants in such
8 model to use certified EHR tech-
9 nology (as defined in subsection
10 (o)(4)); and

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

17 “(ii)(I) bears financial risk for mone-
18 tary losses under such alternative payment
19 model that are in excess of a nominal
20 amount; or

21 “(II) is a medical home expanded
22 under section 1115A(c).

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

1 “(A) The determination that an eligible
2 professional is a qualifying APM participant
3 under paragraph (2) and the determination
4 that an entity is an eligible alternative payment
5 entity under paragraph (3)(D).

6 “(B) The determination of the amount of
7 the 5 percent payment incentive under para-
8 graph (1)(A), including any estimation as part
9 of such determination.”.

10 (3) COORDINATION CONFORMING AMEND-
11 MENTS.—Section 1833 of the Social Security Act
12 (42 U.S.C. 1395l) is further amended—

13 (A) in subsection (x)(3), by adding at the
14 end the following new sentence: “The amount
15 of the additional payment for a service under
16 this subsection and subsection (z) shall be de-
17 termined without regard to any additional pay-
18 ment for the service under subsection (z) and
19 this subsection, respectively.”; and

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

1 ment for the service under subsection (z) and
2 this subsection, respectively.”.

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

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

9 “(xxi) Focusing primarily on physi-
10 cians’ services (as defined in section
11 1848(j)(3)) furnished by physicians who
12 are not primary care practitioners.

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

15 “(xxiii) Focusing on risk-based models
16 for small physician practices which may in-
17 volve two-sided risk and prospective patient
18 assignment, and which examine risk-ad-
19 justed decreases in mortality rates, hos-
20 pital readmissions rates, and other relevant
21 and appropriate clinical measures.

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

1 (B) in subparagraph (C)(viii), by striking
2 “other public sector or private sector payers”
3 and inserting “other public sector payers, pri-
4 vate sector payers, or statewide payment mod-
5 els”.

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

16 (6) INTEGRATING MEDICARE ADVANTAGE AL-
17 TERNATIVE PAYMENT MODELS.—Not later than July
18 1, 2016, the Secretary of Health and Human Serv-
19 ices shall submit to Congress a study that examines
20 the feasibility of integrating alternative payment
21 models in the Medicare Advantage payment system.
22 The study shall include the feasibility of including a
23 value-based modifier and whether such modifier
24 should be budget neutral.

1 (7) STUDY AND REPORT ON FRAUD RELATED
2 TO ALTERNATIVE PAYMENT MODELS UNDER THE
3 MEDICARE PROGRAM.—

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

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

16 (ii) identifies aspects of such alter-
17 native payment models that are vulnerable
18 to fraudulent activity; and

19 (iii) examines the implications of waiv-
20 ers to such laws granted in support of such
21 alternative payment models, including
22 under any potential expansion of such
23 models.

24 (B) REPORT.—Not later than 2 years after
25 the date of the enactment of this Act, the Sec-

1 retary shall submit to Congress a report con-
 2 taining the results of the study conducted under
 3 subparagraph (A). Such report shall include
 4 recommendations for actions to be taken to re-
 5 duce the vulnerability of such alternative pay-
 6 ment models to fraudulent activity. Such report
 7 also shall include, as appropriate, recommenda-
 8 tions of the Inspector General for changes in
 9 Federal fraud prevention laws to reduce such
 10 vulnerability.

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

17 “(r) COLLABORATING WITH THE PHYSICIAN, PRAC-
 18 TITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO
 19 IMPROVE RESOURCE USE MEASUREMENT.—

20 “(1) IN GENERAL.—In order to involve the phy-
 21 sician, practitioner, and other stakeholder commu-
 22 nities in enhancing the infrastructure for resource
 23 use measurement, including for purposes of the
 24 Merit-based Incentive Payment System under sub-
 25 section (q) and alternative payment models under

1 section 1833(z), the Secretary shall undertake the
 2 steps described in the succeeding provisions of this
 3 subsection.

4 “(2) DEVELOPMENT OF CARE EPISODE AND PA-
 5 TIENT CONDITION GROUPS AND CLASSIFICATION
 6 CODES.—

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

12 “(B) PUBLIC AVAILABILITY OF EXISTING
 13 EFFORTS TO DESIGN AN EPISODE GROUPE.—
 14 Not later than 180 days after the date of the
 15 enactment of this subsection, the Secretary
 16 shall post on the Internet website of the Cen-
 17 ters for Medicare & Medicaid Services a list of
 18 the episode groups developed pursuant to sub-
 19 section (n)(9)(A) and related descriptive infor-
 20 mation.

21 “(C) STAKEHOLDER INPUT.—The Sec-
 22 retary shall accept, through the date that is
 23 120 days after the day the Secretary posts the
 24 list pursuant to subparagraph (B), suggestions
 25 from physician specialty societies, applicable

practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

“(i) care episode groups; and

“(ii) patient condition groups.

“(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

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

“(I) establish care episode groups and patient condition groups, which account for a target of an estimated $\frac{1}{2}$ of expenditures under parts A and B (with such target increasing over time as appropriate); and

“(II) assign codes to such groups.

“(ii) CARE EPISODE GROUPS.—In establishing the care episode groups under

1 clause (i), the Secretary shall take into ac-
2 count—

3 “(I) the patient’s clinical prob-
4 lems at the time items and services
5 are furnished during an episode of
6 care, such as the clinical conditions or
7 diagnoses, whether or not inpatient
8 hospitalization occurs, and the prin-
9 cipal procedures or services furnished;
10 and

11 “(II) other factors determined
12 appropriate by the Secretary.

13 “(iii) PATIENT CONDITION GROUPS.—
14 In establishing the patient condition
15 groups under clause (i), the Secretary shall
16 take into account—

17 “(I) the patient’s clinical history
18 at the time of a medical visit, such as
19 the patient’s combination of chronic
20 conditions, current health status, and
21 recent significant history (such as
22 hospitalization and major surgery dur-
23 ing a previous period, such as 3
24 months); and

1 “(II) other factors determined
2 appropriate by the Secretary, such as
3 eligibility status under this title (in-
4 cluding eligibility under section
5 226(a), 226(b), or 226A, and dual eli-
6 gibility under this title and title XIX).

7 “(E) DRAFT CARE EPISODE AND PATIENT
8 CONDITION GROUPS AND CLASSIFICATION
9 CODES.—Not later than 270 days after the end
10 of the comment period described in subpara-
11 graph (C), the Secretary shall post on the
12 Internet website of the Centers for Medicare &
13 Medicaid Services a draft list of the care epi-
14 sode and patient condition codes established
15 under subparagraph (D) (and the criteria and
16 characteristics assigned to such code).

17 “(F) SOLICITATION OF INPUT.—The Sec-
18 retary shall seek, through the date that is 120
19 days after the Secretary posts the list pursuant
20 to subparagraph (E), comments from physician
21 specialty societies, applicable practitioner orga-
22 nizations, and other stakeholders, including rep-
23 resentatives of individuals entitled to benefits
24 under part A or enrolled under this part, re-
25 garding the care episode and patient condition

1 groups (and codes) posted under subparagraph
2 (E). In seeking such comments, the Secretary
3 shall use one or more mechanisms (other than
4 notice and comment rulemaking) that may in-
5 clude use of open door forums, town hall meet-
6 ings, or other appropriate mechanisms.

7 “(G) OPERATIONAL LIST OF CARE EPI-
8 SODE AND PATIENT CONDITION GROUPS AND
9 CODES.—Not later than 270 days after the end
10 of the comment period described in subpara-
11 graph (F), taking into account the comments
12 received under such subparagraph, the Sec-
13 retary shall post on the Internet website of the
14 Centers for Medicare & Medicaid Services an
15 operational list of care episode and patient con-
16 dition codes (and the criteria and characteris-
17 tics assigned to such code).

18 “(H) SUBSEQUENT REVISIONS.—Not later
19 than November 1 of each year (beginning with
20 2018), the Secretary shall, through rulemaking,
21 make revisions to the operational lists of care
22 episode and patient condition codes as the Sec-
23 retary determines may be appropriate. Such re-
24 visions may be based on experience, new infor-
25 mation developed pursuant to subsection

(n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

“(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

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

“(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories),

1 such as a physician or applicable practitioner
2 who—

3 “(i) considers himself to have the
4 primary responsibility for the general and
5 ongoing care for the patient over extended
6 periods of time;

7 “(ii) considers himself to be the lead
8 physician or practitioner and who furnishes
9 items and services and coordinates care
10 furnished by other physicians or practi-
11 tioners for the patient during an acute epi-
12 sode;

13 “(iii) furnishes items and services to
14 the patient on a continuing basis during an
15 acute episode of care, but in a supportive
16 rather than a lead role;

17 “(iv) furnishes items and services to
18 the patient on an occasional basis, usually
19 at the request of another physician or
20 practitioner; or

21 “(v) furnishes items and services only
22 as ordered by another physician or practi-
23 tioner.

24 “(C) DRAFT LIST OF PATIENT RELATION-
25 SHIP CATEGORIES AND CODES.—Not later than

1 one year after the date of the enactment of this
2 subsection, the Secretary shall post on the
3 Internet website of the Centers for Medicare &
4 Medicaid Services a draft list of the patient re-
5 lationship categories and codes developed under
6 subparagraph (B).

7 “(D) STAKEHOLDER INPUT.—The Sec-
8 retary shall seek, through the date that is 120
9 days after the Secretary posts the list pursuant
10 to subparagraph (C), comments from physician
11 specialty societies, applicable practitioner orga-
12 nizations, and other stakeholders, including rep-
13 resentatives of individuals entitled to benefits
14 under part A or enrolled under this part, re-
15 garding the patient relationship categories and
16 codes posted under subparagraph (C). In seek-
17 ing such comments, the Secretary shall use one
18 or more mechanisms (other than notice and
19 comment rulemaking) that may include open
20 door forums, town hall meetings, web-based fo-
21 rums, or other appropriate mechanisms.

22 “(E) OPERATIONAL LIST OF PATIENT RE-
23 LATIONSHIP CATEGORIES AND CODES.—Not
24 later than 240 days after the end of the com-
25 ment period described in subparagraph (D),

1 taking into account the comments received
2 under such subparagraph, the Secretary shall
3 post on the Internet website of the Centers for
4 Medicare & Medicaid Services an operational
5 list of patient relationship categories and codes.

6 “(F) SUBSEQUENT REVISIONS.—Not later
7 than November 1 of each year (beginning with
8 2018), the Secretary shall, through rulemaking,
9 make revisions to the operational list of patient
10 relationship categories and codes as the Sec-
11 retary determines appropriate. Such revisions
12 may be based on experience, new information
13 developed pursuant to subsection (n)(9)(A), and
14 input from the physician specialty societies, ap-
15 plicable practitioner organizations, and other
16 stakeholders, including representatives of indi-
17 viduals entitled to benefits under part A or en-
18 rolled under this part.

19 “(4) REPORTING OF INFORMATION FOR RE-
20 SOURCE USE MEASUREMENT.—Claims submitted for
21 items and services furnished by a physician or appli-
22 cable practitioner on or after January 1, 2018, shall,
23 as determined appropriate by the Secretary, in-
24 clude—

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

3 “(B) the national provider identifier of the
4 ordering physician or applicable practitioner (if
5 different from the billing physician or applicable
6 practitioner).

7 “(5) METHODOLOGY FOR RESOURCE USE ANAL-
8 YSIS.—

9 “(A) IN GENERAL.—In order to evaluate
10 the resources used to treat patients (with re-
11 spect to care episode and patient condition
12 groups), the Secretary shall, as the Secretary
13 determines appropriate—

14 “(i) use the patient relationship codes
15 reported on claims pursuant to paragraph
16 (4) to attribute patients (in whole or in
17 part) to one or more physicians and appli-
18 cable practitioners;

19 “(ii) use the care episode and patient
20 condition codes reported on claims pursu-
21 ant to paragraph (4) as a basis to compare
22 similar patients and care episodes and pa-
23 tient condition groups; and

1 “(iii) conduct an analysis of resource
2 use (with respect to care episodes and pa-
3 tient condition groups of such patients).

4 “(B) ANALYSIS OF PATIENTS OF PHYSI-
5 CIANS AND PRACTITIONERS.—In conducting the
6 analysis described in subparagraph (A)(iii) with
7 respect to patients attributed to physicians and
8 applicable practitioners, the Secretary shall, as
9 feasible—

10 “(i) use the claims data experience of
11 such patients by patient condition codes
12 during a common period, such as 12
13 months; and

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

16 “(I) in the case of episodes with-
17 out a hospitalization, during periods
18 of time (such as the number of days)
19 determined appropriate by the Sec-
20 retary; and

21 “(II) in the case of episodes with
22 a hospitalization, during periods of
23 time (such as the number of days) be-
24 fore, during, and after the hospitaliza-
25 tion.

1 “(C) MEASUREMENT OF RESOURCE USE.—

2 In measuring such resource use, the Sec-
3 retary—

4 “(i) shall use per patient total allowed
5 charges for all services under part A and
6 this part (and, if the Secretary determines
7 appropriate, part D) for the analysis of pa-
8 tient resource use, by care episode codes
9 and by patient condition codes; and

10 “(ii) may, as determined appropriate,
11 use other measures of allowed charges
12 (such as subtotals for categories of items
13 and services) and measures of utilization of
14 items and services (such as frequency of
15 specific items and services and the ratio of
16 specific items and services among attrib-
17 uted patients or episodes).

18 “(D) STAKEHOLDER INPUT.—The Sec-
19 retary shall seek comments from the physician
20 specialty societies, applicable practitioner orga-
21 nizations, and other stakeholders, including rep-
22 resentatives of individuals entitled to benefits
23 under part A or enrolled under this part, re-
24 garding the resource use methodology estab-
25 lished pursuant to this paragraph. In seeking

1 comments the Secretary shall use one or more
2 mechanisms (other than notice and comment
3 rulemaking) that may include open door fo-
4 rums, town hall meetings, web-based forums, or
5 other appropriate mechanisms.

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

15 “(7) LIMITATION.—There shall be no adminis-
16 trative or judicial review under section 1869, section
17 1878, or otherwise of—

18 “(A) care episode and patient condition
19 groups and codes established under paragraph
20 (2);

21 “(B) patient relationship categories and
22 codes established under paragraph (3); and

23 “(C) measurement of, and analyses of re-
24 source use with respect to, care episode and pa-

1 tient condition codes and patient relationship
2 codes pursuant to paragraph (5).

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

5 “(9) DEFINITIONS.—In this subsection:

6 “(A) PHYSICIAN.—The term ‘physician’
7 has the meaning given such term in section
8 1861(r)(1).

9 “(B) APPLICABLE PRACTITIONER.—The
10 term ‘applicable practitioner’ means—

11 “(i) a physician assistant, nurse prac-
12 titioner, and clinical nurse specialist (as
13 such terms are defined in section
14 1861(aa)(5)), and a certified registered
15 nurse anesthetist (as defined in section
16 1861(bb)(2)); and

17 “(ii) beginning January 1, 2019, such
18 other eligible professionals (as defined in
19 subsection (k)(3)(B)) as specified by the
20 Secretary.

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

1 **SEC. 102. PRIORITIES AND FUNDING FOR MEASURE DEVEL-**
2 **OPMENT.**

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

7 “(s) PRIORITIES AND FUNDING FOR MEASURE DE-
8 VELOPMENT.—

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

11 “(A) DRAFT MEASURE DEVELOPMENT
12 PLAN.—Not later than January 1, 2016, the
13 Secretary shall develop, and post on the Inter-
14 net website of the Centers for Medicare & Med-
15 icaid Services, a draft plan for the development
16 of quality measures for application under the
17 applicable provisions (as defined in paragraph
18 (5)). Under such plan the Secretary shall—

19 “(i) address how measures used by
20 private payers and integrated delivery sys-
21 tems could be incorporated under title
22 XVIII;

23 “(ii) describe how coordination, to the
24 extent possible, will occur across organiza-
25 tions developing such measures; and

1 “(iii) take into account how clinical
2 best practices and clinical practice guide-
3 lines should be used in the development of
4 quality measures.

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

8 “(i) Clinical care.

9 “(ii) Safety.

10 “(iii) Care coordination.

11 “(iv) Patient and caregiver experience.

12 “(v) Population health and preven-
13 tion.

14 “(C) CONSIDERATION.—In developing the
15 draft plan under this paragraph, the Secretary
16 shall consider—

17 “(i) gap analyses conducted by the en-
18 tity with a contract under section 1890(a)
19 or other contractors or entities;

20 “(ii) whether measures are applicable
21 across health care settings;

22 “(iii) clinical practice improvement ac-
23 tivities submitted under subsection
24 (q)(2)(C)(iv) for identifying possible areas
25 for future measure development and identi-

1 fying existing gaps with respect to such
2 measures; and

3 “(iv) the quality domains applied
4 under this subsection.

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

8 “(i) Outcome measures, including pa-
9 tient reported outcome and functional sta-
10 tus measures.

11 “(ii) Patient experience measures.

12 “(iii) Care coordination measures.

13 “(iv) Measures of appropriate use of
14 services, including measures of over use.

15 “(E) STAKEHOLDER INPUT.—The Sec-
16 retary shall accept through March 1, 2016,
17 comments on the draft plan posted under para-
18 graph (1)(A) from the public, including health
19 care providers, payers, consumers, and other
20 stakeholders.

21 “(F) FINAL MEASURE DEVELOPMENT
22 PLAN.—Not later than May 1, 2016, taking
23 into account the comments received under this
24 subparagraph, the Secretary shall finalize the
25 plan and post on the Internet website of the

Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under the applicable provisions. Such plan shall be updated as appropriate.

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

“(A) IN GENERAL.—The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding in accordance with the plan under paragraph (1) quality measures for application under the applicable provisions. Such entities shall include organizations with quality measure development expertise.

“(B) PRIORITIZATION.—

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

“(ii) CONSIDERATION.—In selecting measures for development under this subsection, the Secretary shall consider—

1 “(I) whether such measures
2 would be electronically specified; and

3 “(II) clinical practice guidelines
4 to the extent that such guidelines
5 exist.

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

7 “(A) IN GENERAL.—Not later than May 1,
8 2017, and annually thereafter, the Secretary
9 shall post on the Internet website of the Cen-
10 ters for Medicare & Medicaid Services a report
11 on the progress made in developing quality
12 measures for application under the applicable
13 provisions.

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

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

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

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

1 “(II) the name of each measure
2 developed;

3 “(III) the name of the developer
4 and steward of each measure;

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

9 “(V) whether the measure would
10 be electronically specified.

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

13 “(I) the information described in
14 clause (ii), if available; and

15 “(II) a timeline for completion of
16 the development of such measures.

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

23 “(v) Other information the Secretary
24 determines to be appropriate.

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

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

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

10 “(C) other areas related to quality measure
11 development determined appropriate by the Sec-
12 retary.

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

16 “(A) Subsection (q)(2)(B)(i).

17 “(B) Section 1833(z)(2)(C).

18 “(6) FUNDING.—For purposes of carrying out
19 this subsection, the Secretary shall provide for the
20 transfer, from the Federal Supplementary Medical
21 Insurance Trust Fund under section 1841, of
22 \$15,000,000 to the Centers for Medicare & Medicaid
23 Services Program Management Account for each of
24 fiscal years 2015 through 2019. Amounts trans-

1 ferred under this paragraph shall remain available
2 through the end of fiscal year 2022.

3 “(7) ADMINISTRATION.—Chapter 35 of title 44,
4 United States Code, shall not apply to the collection
5 of information for the development of quality meas-
6 ures.”.

7 **SEC. 103. ENCOURAGING CARE MANAGEMENT FOR INDIV-**
8 **VIDUALS WITH CHRONIC CARE NEEDS.**

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

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

14 “(A) IN GENERAL.—In order to encourage
15 the management of care for individuals with
16 chronic care needs the Secretary shall, subject
17 to subparagraph (B), make payment (as the
18 Secretary determines to be appropriate) under
19 this section for chronic care management serv-
20 ices furnished on or after January 1, 2015, by
21 a physician (as defined in section 1861(r)(1)),
22 physician assistant or nurse practitioner (as de-
23 fined in section 1861(aa)(5)(A)), clinical nurse
24 specialist (as defined in section

1 1861(aa)(5)(B)), or certified nurse midwife (as
 2 defined in section 1861(gg)(2)).

3 “(B) POLICIES RELATING TO PAYMENT.—

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

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

10 “(ii) not make payment under sub-
 11 paragraph (A) if such payment would be
 12 duplicative of payment that is otherwise
 13 made under this title for such 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.—Not later than December 31,
20 2017, the Secretary shall submit to Congress a re-
21 port on the use of chronic care management services
22 described in such section 1848(b)(8) by individuals
23 living in rural areas and by racial and ethnic minor-
24 ity populations. Such report shall—

1 (A) identify barriers to receiving chronic
2 care management services; and

3 (B) make recommendations for increasing
4 the appropriate use of chronic care manage-
5 ment services.

6 **SEC. 104. EMPOWERING BENEFICIARY CHOICES THROUGH**
7 **CONTINUED ACCESS TO INFORMATION ON**
8 **PHYSICIANS' SERVICES.**

9 (a) IN GENERAL.—On an annual basis (beginning
10 with 2015), the Secretary shall make publicly available,
11 in an easily understandable format, information with re-
12 spect to physicians and, as appropriate, other eligible pro-
13 fessionals on items and services furnished to Medicare
14 beneficiaries under title XVIII of the Social Security Act
15 (42 U.S.C. 1395 et seq.).

16 (b) TYPE AND MANNER OF INFORMATION.—The in-
17 formation made available under this section shall be simi-
18 lar to the type of information in the Medicare Provider
19 Utilization and Payment Data: Physician and Other Sup-
20 plier Public Use File released by the Secretary with re-
21 spect to 2012 and shall be made available in a manner
22 similar to the manner in which the information in such
23 File is made available.

1 (c) REQUIREMENTS.—The information made avail-
2 able under this section shall include, at a minimum, the
3 following:

4 (1) Information on the number of services fur-
5 nished by the physician or other eligible professional
6 under part B of title XVIII of the Social Security
7 Act (42 U.S.C. 1395j et seq.), which may include in-
8 formation on the most frequent services furnished or
9 groupings of services.

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

12 (3) A unique identifier for the physician or
13 other eligible professional that is available to the
14 public, such as a national provider identifier.

15 (d) SEARCHABILITY.—The information made avail-
16 able under this section shall be searchable by at least the
17 following:

18 (1) The specialty or type of the physician or
19 other eligible professional.

20 (2) Characteristics of the services furnished,
21 such as volume or groupings of services.

22 (3) The location of the physician or other eligi-
23 ble professional.

24 (e) INTEGRATION ON PHYSICIAN COMPARE.—Begin-
25 ning with 2016, the Secretary shall integrate the informa-

1 tion made available under this section on Physician Com-
 2 pare.

3 (f) DEFINITIONS.—In this section:

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

8 (2) PHYSICIAN COMPARE.—The term “Physi-
 9 cian Compare” means the Physician Compare Inter-
 10 net website of the Centers for Medicare & Medicaid
 11 Services (or a successor website).

12 **SEC. 105. EXPANDING AVAILABILITY OF MEDICARE DATA.**

13 (a) EXPANDING USES OF MEDICARE DATA BY
 14 QUALIFIED ENTITIES.—

15 (1) ADDITIONAL ANALYSES.—

16 (A) IN GENERAL.—Subject to subpara-
 17 graph (B), to the extent consistent with appli-
 18 cable information, privacy, security, and disclo-
 19 sure laws (including paragraph (3)), notwith-
 20 standing paragraph (4)(B) of section 1874(e) of
 21 the Social Security Act (42 U.S.C. 1395kk(e))
 22 and the second sentence of paragraph (4)(D) of
 23 such section, beginning July 1, 2016, a quali-
 24 fied entity may use the combined data described
 25 in paragraph (4)(B)(iii) of such section received

1 by such entity under such section, and informa-
2 tion derived from the evaluation described in
3 such paragraph (4)(D), to conduct additional
4 non-public analyses (as determined appropriate
5 by the Secretary) and provide or sell such anal-
6 yses to authorized users for non-public use (in-
7 cluding for the purposes of assisting providers
8 of services and suppliers to develop and partici-
9 pate in quality and patient care improvement
10 activities, including developing new models of
11 care).

12 (B) LIMITATIONS WITH RESPECT TO ANAL-
13 YSES.—

14 (i) EMPLOYERS.—Any analyses pro-
15 vided or sold under subparagraph (A) to
16 an employer described in paragraph
17 (9)(A)(iii) may only be used by such em-
18 ployer for purposes of providing health in-
19 surance to employees and retirees of the
20 employer.

21 (ii) HEALTH INSURANCE ISSUERS.—A
22 qualified entity may not provide or sell an
23 analysis to a health insurance issuer de-
24 scribed in paragraph (9)(A)(iv) unless the
25 issuer is providing the qualified entity with

1 data under section 1874(e)(4)(B)(iii) of
2 the Social Security Act (42 U.S.C.
3 1395kk(e)(4)(B)(iii)).

4 (2) ACCESS TO CERTAIN DATA.—

5 (A) ACCESS.—To the extent consistent
6 with applicable information, privacy, security,
7 and disclosure laws (including paragraph (3)),
8 notwithstanding paragraph (4)(B) of section
9 1874(e) of the Social Security Act (42 U.S.C.
10 1395kk(e)) and the second sentence of para-
11 graph (4)(D) of such section, beginning July 1,
12 2016, a qualified entity may—

13 (i) provide or sell the combined data
14 described in paragraph (4)(B)(iii) of such
15 section to authorized users described in
16 clauses (i), (ii), and (v) of paragraph
17 (9)(A) for non-public use, including for the
18 purposes described in subparagraph (B);
19 or

20 (ii) subject to subparagraph (C), pro-
21 vide Medicare claims data to authorized
22 users described in clauses (i), (ii), and (v),
23 of paragraph (9)(A) for non-public use, in-
24 cluding for the purposes described in sub-
25 paragraph (B).

1 (B) PURPOSES DESCRIBED.—The purposes
2 described in this subparagraph are assisting
3 providers of services and suppliers in developing
4 and participating in quality and patient care
5 improvement activities, including developing
6 new models of care.

7 (C) MEDICARE CLAIMS DATA MUST BE
8 PROVIDED AT NO COST.—A qualified entity may
9 not charge a fee for providing the data under
10 subparagraph (A)(ii).

11 (3) PROTECTION OF INFORMATION.—

12 (A) IN GENERAL.—Except as provided in
13 subparagraph (B), an analysis or data that is
14 provided or sold under paragraph (1) or (2)
15 shall not contain information that individually
16 identifies a patient.

17 (B) INFORMATION ON PATIENTS OF THE
18 PROVIDER OF SERVICES OR SUPPLIER.—To the
19 extent consistent with applicable information,
20 privacy, security, and disclosure laws, an anal-
21 ysis or data that is provided or sold to a pro-
22 vider of services or supplier under paragraph
23 (1) or (2) may contain information that individ-
24 ually identifies a patient of such provider or
25 supplier, including with respect to items and

1 services furnished to the patient by other pro-
2 viders of services or suppliers.

3 (C) PROHIBITION ON USING ANALYSES OR
4 DATA FOR MARKETING PURPOSES.—An author-
5 ized user shall not use an analysis or data pro-
6 vided or sold under paragraph (1) or (2) for
7 marketing purposes.

8 (4) DATA USE AGREEMENT.—A qualified entity
9 and an authorized user described in clauses (i), (ii),
10 and (v) of paragraph (9)(A) shall enter into an
11 agreement regarding the use of any data that the
12 qualified entity is providing or selling to the author-
13 ized user under paragraph (2). Such agreement shall
14 describe the requirements for privacy and security of
15 the data and, as determined appropriate by the Sec-
16 retary, any prohibitions on using such data to link
17 to other individually identifiable sources of informa-
18 tion. If the authorized user is not a covered entity
19 under the rules promulgated pursuant to the Health
20 Insurance Portability and Accountability Act of
21 1996, the agreement shall identify the relevant regu-
22 lations, as determined by the Secretary, that the
23 user shall comply with as if it were acting in the ca-
24 pacity of such a covered entity.

1 (5) NO REDISCLOSURE OF ANALYSES OR
2 DATA.—

3 (A) IN GENERAL.—Except as provided in
4 subparagraph (B), an authorized user that is
5 provided or sold an analysis or data under
6 paragraph (1) or (2) shall not redisclose or
7 make public such analysis or data or any anal-
8 ysis using such data.

9 (B) PERMITTED REDISCLOSURE.—A pro-
10 vider of services or supplier that is provided or
11 sold an analysis or data under paragraph (1) or
12 (2) may, as determined by the Secretary, redis-
13 close such analysis or data for the purposes of
14 performance improvement and care coordination
15 activities but shall not make public such anal-
16 ysis or data or any analysis using such data.

17 (6) OPPORTUNITY FOR PROVIDERS OF SERV-
18 ICES AND SUPPLIERS TO REVIEW.—Prior to a quali-
19 fied entity providing or selling an analysis to an au-
20 thorized user under paragraph (1), to the extent
21 that such analysis would individually identify a pro-
22 vider of services or supplier who is not being pro-
23 vided or sold such analysis, such qualified entity
24 shall provide such provider or supplier with the op-
25 portunity to appeal and correct errors in the manner

described in section 1874(e)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

(7) ASSESSMENT FOR A BREACH.—

(A) IN GENERAL.—In the case of a breach of a data use agreement under this section or section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)), the Secretary shall impose an assessment on the qualified entity both in the case of—

(i) an agreement between the Secretary and a qualified entity; and

(ii) an agreement between a qualified entity and an authorized user.

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

(i) in the case of an agreement described in subparagraph (A)(i), for whom the Secretary provided data on to the qualified entity under paragraph (2); and

(ii) in the case of an agreement described in subparagraph (A)(ii), for whom

1 the qualified entity provided data on to the
2 authorized user under paragraph (2).

3 (C) DEPOSIT OF AMOUNTS COLLECTED.—

4 Any amounts collected pursuant to this para-
5 graph shall be deposited in Federal Supple-
6 mentary Medical Insurance Trust Fund under
7 section 1841 of the Social Security Act (42
8 U.S.C. 1395t).

9 (8) ANNUAL REPORTS.—Any qualified entity
10 that provides or sells an analysis or data under
11 paragraph (1) or (2) shall annually submit to the
12 Secretary a report that includes—

13 (A) a summary of the analyses provided or
14 sold, including the number of such analyses, the
15 number of purchasers of such analyses, and the
16 total amount of fees received for such analyses;

17 (B) a description of the topics and pur-
18 poses of such analyses;

19 (C) information on the entities who re-
20 ceived the data under paragraph (2), the uses
21 of the data, and the total amount of fees re-
22 ceived for providing, selling, or sharing the
23 data; and

24 (D) other information determined appro-
25 priate by the Secretary.

1 (9) DEFINITIONS.—In this subsection and sub-
2 section (b):

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

5 (i) A provider of services.

6 (ii) A supplier.

7 (iii) An employer (as defined in sec-
8 tion 3(5) of the Employee Retirement In-
9 surance Security Act of 1974).

10 (iv) A health insurance issuer (as de-
11 fined in section 2791 of the Public Health
12 Service Act).

13 (v) A medical society or hospital asso-
14 ciation.

15 (vi) Any entity not described in
16 clauses (i) through (v) that is approved by
17 the Secretary (other than an employer or
18 health insurance issuer not described in
19 clauses (iii) and (iv), respectively, as deter-
20 mined by the Secretary).

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

1 (C) QUALIFIED ENTITY.—The term “quali-
2 fied entity” has the meaning given such term in
3 section 1874(e)(2) of the Social Security Act
4 (42 U.S.C. 1395kk(e)).

5 (D) SECRETARY.—The term “Secretary”
6 means the Secretary of Health and Human
7 Services.

8 (E) SUPPLIER.—The term “supplier” has
9 the meaning given such term in section 1861(d)
10 of the Social Security Act (42 U.S.C.
11 1395x(d)).

12 (b) ACCESS TO MEDICARE DATA BY QUALIFIED
13 CLINICAL DATA REGISTRIES TO FACILITATE QUALITY
14 IMPROVEMENT.—

15 (1) ACCESS.—

16 (A) IN GENERAL.—To the extent con-
17 sistent with applicable information, privacy, se-
18 curity, and disclosure laws, beginning July 1,
19 2016, the Secretary shall, at the request of a
20 qualified clinical data registry under section
21 1848(m)(3)(E) of the Social Security Act (42
22 U.S.C. 1395w–4(m)(3)(E)), provide the data
23 described in subparagraph (B) (in a form and
24 manner determined to be appropriate) to such
25 qualified clinical data registry for purposes of

1 linking such data with clinical outcomes data
2 and performing risk-adjusted, scientifically valid
3 analyses and research to support quality im-
4 provement or patient safety, provided that any
5 public reporting of such analyses or research
6 that identifies a provider of services or supplier
7 shall only be conducted with the opportunity of
8 such provider or supplier to appeal and correct
9 errors in the manner described in subsection
10 (a)(6).

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

13 (i) claims data under the Medicare
14 program under title XVIII of the Social
15 Security Act; and

16 (ii) if the Secretary determines appro-
17 priate, claims data under the Medicaid
18 program under title XIX of such Act and
19 the State Children’s Health Insurance Pro-
20 gram under title XXI of such Act.

21 (2) FEE.—Data described in paragraph (1)(B)
22 shall be provided to a qualified clinical data registry
23 under paragraph (1) at a fee equal to the cost of
24 providing such data. Any fee collected pursuant to
25 the preceding sentence shall be deposited in the Cen-

1 ters for Medicare & Medicaid Services Program
2 Management Account.

3 (c) EXPANSION OF DATA AVAILABLE TO QUALIFIED
4 ENTITIES.—Section 1874(e) of the Social Security Act
5 (42 U.S.C. 1395kk(e)) is amended—

6 (1) in the subsection heading, by striking
7 “MEDICARE”; and

8 (2) in paragraph (3)—

9 (A) by inserting after the first sentence the
10 following new sentence: “Beginning July 1,
11 2016, if the Secretary determines appropriate,
12 the data described in this paragraph may also
13 include standardized extracts (as determined by
14 the Secretary) of claims data under titles XIX
15 and XXI for assistance provided under such ti-
16 tles for one or more specified geographic areas
17 and time periods requested by a qualified enti-
18 ty.”; and

19 (B) in the last sentence, by inserting “or
20 under titles XIX or XXI” before the period at
21 the end.

22 (d) REVISION OF PLACEMENT OF FEES.—Section
23 1874(e)(4)(A) of the Social Security Act (42 U.S.C.
24 1395kk(e)(4)(A)) is amended, in the second sentence—

1 (1) by inserting “, for periods prior to July 1,
2 2016,” after “deposited”; and

3 (2) by inserting the following before the period
4 at the end: “, and, beginning July 1, 2016, into the
5 Centers for Medicare & Medicaid Services Program
6 Management Account”.

7 **SEC. 106. REDUCING ADMINISTRATIVE BURDEN AND**
8 **OTHER PROVISIONS.**

9 (a) **MEDICARE PHYSICIAN AND PRACTITIONER OPT-**
10 **OUT TO PRIVATE CONTRACT.—**

11 (1) **INDEFINITE, CONTINUING AUTOMATIC EX-**
12 **TENSION OF OPT OUT ELECTION.—**

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

16 (i) in subparagraph (B)(ii), by strik-
17 ing “during the 2-year period beginning on
18 the date the affidavit is signed” and insert-
19 ing “during the applicable 2-year period
20 (as defined in subparagraph (D))”;

21 (ii) in subparagraph (C), by striking
22 “during the 2-year period described in sub-
23 paragraph (B)(ii)” and inserting “during
24 the applicable 2-year period”; and

1 (iii) by adding at the end the fol-
2 lowing new subparagraph:

3 “(D) APPLICABLE 2-YEAR PERIODS FOR
4 EFFECTIVENESS OF AFFIDAVITS.—In this sub-
5 section, the term ‘applicable 2-year period’
6 means, with respect to an affidavit of a physi-
7 cian or practitioner under subparagraph (B),
8 the 2-year period beginning on the date the af-
9 fidavit is signed and includes each subsequent
10 2-year period unless the physician or practi-
11 tioner involved provides notice to the Secretary
12 (in a form and manner specified by the Sec-
13 retary), not later than 30 days before the end
14 of the previous 2-year period, that the physician
15 or practitioner does not want to extend the ap-
16 plication of the affidavit for such subsequent 2-
17 year period.”.

18 (B) EFFECTIVE DATE.—The amendments
19 made by subparagraph (A) shall apply to affi-
20 davits entered into on or after the date that is
21 60 days after the date of the enactment of this
22 Act.

23 (2) PUBLIC AVAILABILITY OF INFORMATION ON
24 OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section

1 1802(b) of the Social Security Act (42 U.S.C.
2 1395a(b)) is amended—

3 (A) in paragraph (5), by adding at the end
4 the following new subparagraph:

5 “(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—

6 The term ‘opt-out physician or practitioner’ means
7 a physician or practitioner who has in effect an affi-
8 davit under paragraph (3)(B).”;

9 (B) by redesignating paragraph (5) as
10 paragraph (6); and

11 (C) by inserting after paragraph (4) the
12 following new paragraph:

13 “(5) POSTING OF INFORMATION ON OPT-OUT
14 PHYSICIANS AND PRACTITIONERS.—

15 “(A) IN GENERAL.—Beginning not later
16 than February 1, 2016, the Secretary shall
17 make publicly available through an appropriate
18 publicly accessible website of the Department of
19 Health and Human Services information on the
20 number and characteristics of opt-out physi-
21 cians and practitioners and shall update such
22 information on such website not less often than
23 annually.

24 “(B) INFORMATION TO BE INCLUDED.—

25 The information to be made available under

1 subparagraph (A) shall include at least the fol-
2 lowing with respect to opt-out physicians and
3 practitioners:

4 “(i) Their number.

5 “(ii) Their physician or professional
6 specialty or other designation.

7 “(iii) Their geographic distribution.

8 “(iv) The timing of their becoming
9 opt-out physicians and practitioners, rel-
10 ative, to the extent feasible, to when they
11 first enrolled in the program under this
12 title and with respect to applicable 2-year
13 periods.

14 “(v) The proportion of such physi-
15 cians and practitioners who billed for
16 emergency or urgent care services.”.

17 (b) GAINSHARING STUDY AND REPORT.—Not later
18 than 6 months after the date of the enactment of this Act,
19 the Secretary of Health and Human Services, in consulta-
20 tion with the Inspector General of the Department of
21 Health and Human Services, shall submit to Congress a
22 report with legislative recommendations to amend existing
23 fraud and abuse laws, through exceptions, safe harbors,
24 or other narrowly targeted provisions, to permit
25 gainsharing or similar arrangements between physicians

1 and hospitals that improve care while reducing waste and
2 increasing efficiency. The report shall—

3 (1) consider whether such provisions should
4 apply to ownership interests, compensation arrange-
5 ments, or other relationships;

6 (2) describe how the recommendations address
7 accountability, transparency, and quality, including
8 how best to limit inducements to stint on care, dis-
9 charge patients prematurely, or otherwise reduce or
10 limit medically necessary care; and

11 (3) consider whether a portion of any savings
12 generated by such arrangements should accrue to
13 the Medicare program under title XVIII of the So-
14 cial Security Act.

15 (c) PROMOTING INTEROPERABILITY OF ELECTRONIC
16 HEALTH RECORD SYSTEMS.—

17 (1) RECOMMENDATIONS FOR ACHIEVING WIDE-
18 SPREAD EHR INTEROPERABILITY.—

19 (A) OBJECTIVE.—As a consequence of a
20 significant Federal investment in the implemen-
21 tation of health information technology through
22 the Medicare and Medicaid EHR incentive pro-
23 grams, Congress declares it a national objective
24 to achieve widespread exchange of health infor-

1 mation through interoperable certified EHR
2 technology nationwide by December 31, 2018.

3 (B) DEFINITIONS.—In this paragraph:

4 (i) WIDESPREAD INTEROPER-
5 ABILITY.—The term “widespread inter-
6 operability” means interoperability between
7 certified EHR technology systems em-
8 ployed by meaningful EHR users under
9 the Medicare and Medicaid EHR incentive
10 programs and other clinicians and health
11 care providers on a nationwide basis.

12 (ii) INTEROPERABILITY.—The term
13 “interoperability” means the ability of two
14 or more health information systems or
15 components to exchange clinical and other
16 information and to use the information
17 that has been exchanged using common
18 standards as to provide access to longitu-
19 dinal information for health care providers
20 in order to facilitate coordinated care and
21 improved patient outcomes.

22 (C) ESTABLISHMENT OF METRICS.—Not
23 later than July 1, 2016, and in consultation
24 with stakeholders, the Secretary shall establish
25 metrics to be used to determine if and to the

1 extent that the objective described in subpara-
 2 graph (A) has been achieved.

3 (D) RECOMMENDATIONS IF OBJECTIVE
 4 NOT ACHIEVED.—If the Secretary of Health
 5 and Human Services determines that the objec-
 6 tive described in subparagraph (A) has not been
 7 achieved by December 31, 2018, then the Sec-
 8 retary shall submit to Congress a report, by not
 9 later than December 31, 2019, that identifies
 10 barriers to such objective and recommends ac-
 11 tions that the Federal Government can take to
 12 achieve such objective. Such recommended ac-
 13 tions may include recommendations—

14 (i) to adjust payments for not being
 15 meaningful EHR users under the Medicare
 16 EHR incentive programs; and

17 (ii) for criteria for decertifying cer-
 18 tified EHR technology products.

19 (2) PREVENTING BLOCKING THE SHARING OF
 20 INFORMATION.—

21 (A) FOR MEANINGFUL USE EHR PROFES-
 22 SIONALS.—Section 1848(o)(2)(A)(ii) of the So-
 23 cial Security Act (42 U.S.C. 1395w-
 24 4(o)(2)(A)(ii)) is amended by inserting before
 25 the period at the end the following: “, and the

1 professional demonstrates (through a process
2 specified by the Secretary, such as the use of an
3 attestation) that the professional has not know-
4 ingly and willfully taken action (such as to dis-
5 able functionality) to limit or restrict the com-
6 patibility or interoperability of the certified
7 EHR technology”.

8 (B) FOR MEANINGFUL USE EHR HOS-
9 PITALS.—Section 1886(n)(3)(A)(ii) of the So-
10 cial Security Act (42 U.S.C.
11 1395ww(n)(3)(A)(ii)) is amended by inserting
12 before the period at the end the following: “,
13 and the hospital demonstrates (through a proc-
14 ess specified by the Secretary, such as the use
15 of an attestation) that the hospital has not
16 knowingly and willfully taken action (such as to
17 disable functionality) to limit or restrict the
18 compatibility or interoperability of the certified
19 EHR technology”.

20 (C) EFFECTIVE DATE.—The amendments
21 made by this subsection shall apply to meaning-
22 ful EHR users as of the date that is one year
23 after the date of the enactment of this Act.

1 (3) STUDY AND REPORT ON THE FEASIBILITY
2 OF ESTABLISHING A MECHANISM TO COMPARE CER-
3 TIFIED EHR TECHNOLOGY PRODUCTS.—

4 (A) STUDY.—The Secretary shall conduct
5 a study to examine the feasibility of estab-
6 lishing one or more mechanisms to assist pro-
7 viders in comparing and selecting certified
8 EHR technology products. Such mechanisms
9 may include—

10 (i) a website with aggregated results
11 of surveys of meaningful EHR users on
12 the functionality of certified EHR tech-
13 nology products to enable such users to di-
14 rectly compare the functionality and other
15 features of such products; and

16 (ii) information from vendors of cer-
17 tified products that is made publicly avail-
18 able in a standardized format.

19 The aggregated results of the surveys described
20 in clause (i) may be made available through
21 contracts with physicians, hospitals, or other or-
22 ganizations that maintain such comparative in-
23 formation described in such clause.

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

retary shall submit to Congress a report on mechanisms that would assist providers in comparing and selecting certified EHR technology products. The report shall include information on the benefits of, and resources needed to develop and maintain, such mechanisms.

(4) DEFINITIONS.—In this subsection:

(A) The term “certified EHR technology” has the meaning given such term in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w–4(o)(4)).

(B) The term “meaningful EHR user” has the meaning given such term under the Medicare EHR incentive programs.

(C) The term “Medicare and Medicaid EHR incentive programs” means—

(i) in the case of the Medicare program under title XVIII of the Social Security Act, the incentive programs under section 1814(l)(3), section 1848(o), subsections (l) and (m) of section 1853, and section 1886(n) of the Social Security Act (42 U.S.C. 1395f(l)(3), 1395w–4(o), 1395w–23, 1395ww(n)); and

1 (ii) in the case of the Medicaid pro-
2 gram under title XIX of such Act, the in-
3 centive program under subsections
4 (a)(3)(F) and (t) of section 1903 of such
5 Act (42 U.S.C. 1396b).

6 (D) The term “Secretary” means the Sec-
7 retary of Health and Human Services.

8 (d) GAO STUDIES AND REPORTS ON THE USE OF
9 TELEHEALTH UNDER FEDERAL PROGRAMS AND ON RE-
10 MOTE PATIENT MONITORING SERVICES.—

11 (1) STUDY ON TELEHEALTH SERVICES.—The
12 Comptroller General of the United States shall con-
13 duct a study on the following:

14 (A) How the definition of telehealth across
15 various Federal programs and Federal efforts
16 can inform the use of telehealth in the Medicare
17 program under title XVIII of the Social Secu-
18 rity Act (42 U.S.C. 1395 et seq.).

19 (B) Issues that can facilitate or inhibit the
20 use of telehealth under the Medicare program
21 under such title, including oversight and profes-
22 sional licensure, changing technology, privacy
23 and security, infrastructure requirements, and
24 varying needs across urban and rural areas.

1 (C) Potential implications of greater use of
2 telehealth with respect to payment and delivery
3 system transformations under the Medicare
4 program under such title XVIII and the Med-
5 icaid program under title XIX of such Act (42
6 U.S.C. 1396 et seq.).

7 (D) How the Centers for Medicare & Med-
8 icaid Services monitors payments made under
9 the Medicare program under such title XVIII to
10 providers for telehealth services.

11 (2) STUDY ON REMOTE PATIENT MONITORING
12 SERVICES.—

13 (A) IN GENERAL.—The Comptroller Gen-
14 eral of the United States shall conduct a
15 study—

16 (i) of the dissemination of remote pa-
17 tient monitoring technology in the private
18 health insurance market;

19 (ii) of the financial incentives in the
20 private health insurance market relating to
21 adoption of such technology;

22 (iii) of the barriers to adoption of
23 such services under the Medicare program
24 under title XVIII of the Social Security
25 Act;

(iv) that evaluates the patients, conditions, and clinical circumstances that could most benefit from remote patient monitoring services; and

(v) that evaluates the challenges related to establishing appropriate valuation for remote patient monitoring services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) in order to accurately reflect the resources involved in furnishing such services.

(B) DEFINITIONS.—For purposes of this paragraph:

(i) REMOTE PATIENT MONITORING SERVICES.—The term “remote patient monitoring services” means services furnished through remote patient monitoring technology.

(ii) REMOTE PATIENT MONITORING TECHNOLOGY.—The term “remote patient monitoring technology” means a coordinated system that uses one or more home-based or mobile monitoring devices that automatically transmit vital sign data or

1 information on activities of daily living and
2 may include responses to assessment ques-
3 tions collected on the devices wirelessly or
4 through a telecommunications connection
5 to a server that complies with the Federal
6 regulations (concerning the privacy of indi-
7 vidually identifiable health information)
8 promulgated under section 264(c) of the
9 Health Insurance Portability and Account-
10 ability Act of 1996, as part of an estab-
11 lished plan of care for that patient that in-
12 cludes the review and interpretation of that
13 data by a health care professional.

14 (3) REPORTS.—Not later than 24 months after
15 the date of the enactment of this Act, the Comp-
16 troller General shall submit to Congress—

17 (A) a report containing the results of the
18 study conducted under paragraph (1); and

19 (B) a report containing the results of the
20 study conducted under paragraph (2).

21 A report required under this paragraph shall be sub-
22 mitted together with recommendations for such leg-
23 islation and administrative action as the Comptroller
24 General determines appropriate. The Comptroller
25 General may submit one report containing the re-

1 sults described in subparagraphs (A) and (B) and
 2 the recommendations described in the previous sen-
 3 tence.

4 (e) RULE OF CONSTRUCTION REGARDING HEALTH
 5 CARE PROVIDERS.—

6 (1) IN GENERAL.—Subject to paragraph (3),
 7 the development, recognition, or implementation of
 8 any guideline or other standard under any Federal
 9 health care provision shall not be construed to estab-
 10 lish the standard of care or duty of care owed by a
 11 health care provider to a patient in any medical mal-
 12 practice or medical product liability action or claim.

13 (2) DEFINITIONS.—For purposes of this sub-
 14 section:

15 (A) FEDERAL HEALTH CARE PROVISION.—

16 The term “Federal health care provision”
 17 means any provision of the Patient Protection
 18 and Affordable Care Act (Public Law 111–
 19 148), title I or subtitle B of title II of the
 20 Health Care and Education Reconciliation Act
 21 of 2010 (Public Law 111–152), or title XVIII
 22 or XIX of the Social Security Act (42 U.S.C.
 23 1395 et seq., 42 U.S.C. 1396 et seq.).

24 (B) HEALTH CARE PROVIDER.—The term
 25 “health care provider” means any individual,

1 group practice, corporation of health care pro-
2 fessionals, or hospital—

3 (i) licensed, registered, or certified
4 under Federal or State laws or regulations
5 to provide health care services; or

6 (ii) required to be so licensed, reg-
7 istered, or certified but that is exempted
8 by other statute or regulation.

9 (C) MEDICAL MALPRACTICE OR MEDICAL
10 PRODUCT LIABILITY ACTION OR CLAIM.—The
11 term “medical malpractice or medical product
12 liability action or claim” means a medical mal-
13 practice action or claim (as defined in section
14 431(7) of the Health Care Quality Improve-
15 ment Act of 1986 (42 U.S.C. 11151(7))) and
16 includes a liability action or claim relating to a
17 health care provider’s prescription or provision
18 of a drug, device, or biological product (as such
19 terms are defined in section 201 of the Federal
20 Food, Drug, and Cosmetic Act (21 U.S.C. 321)
21 or section 351 of the Public Health Service Act
22 (42 U.S.C. 262)).

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) NO PREEMPTION.—Nothing in paragraph
4 (1) or any provision of the Patient Protection and
5 Affordable Care Act (Public Law 111–148), title I
6 or subtitle B of title II of the Health Care and Edu-
7 cation Reconciliation Act of 2010 (Public Law 111–
8 152), or title XVIII or XIX of the Social Security
9 Act (42 U.S.C. 1395 et seq., 42 U.S.C. 1396 et
10 seq.) shall be construed to preempt any State or
11 common law governing medical professional or med-
12 ical product liability actions or claims.

13 **TITLE II—MEDICARE AND**
14 **OTHER HEALTH EXTENDERS**
15 **Subtitle A—Medicare Extenders**

16 **SEC. 201. EXTENSION OF WORK GPCI FLOOR.**

17 Section 1848(e)(1)(E) of the Social Security Act (42
18 U.S.C. 1395w–4(e)(1)(E)) is amended by striking “April
19 1, 2015” and inserting “January 1, 2018”.

20 **SEC. 202. EXTENSION OF THERAPY CAP EXCEPTIONS PROC-**
21 **ESS.**

22 (a) IN GENERAL.—Section 1833(g) of the Social Se-
23 curity Act (42 U.S.C. 1395l(g)) is amended—

1 (1) in paragraph (5)(A), in the first sentence,
 2 by striking “March 31, 2015” and inserting “De-
 3 cember 31, 2017”; and

4 (2) in paragraph (6)(A)—

5 (A) by striking “March 31, 2015” and in-
 6 serting “December 31, 2017”; and

7 (B) by striking “2012, 2013, 2014, or the
 8 first three months of 2015” and inserting
 9 “2012 through 2017”.

10 (b) TARGETED REVIEWS UNDER MANUAL MEDICAL
 11 REVIEW PROCESS FOR OUTPATIENT THERAPY SERV-
 12 ICES.—

13 (1) IN GENERAL.—Section 1833(g)(5) of the
 14 Social Security Act (42 U.S.C. 1395l(g)(5)) is
 15 amended—

16 (A) in subparagraph (C)(i), by inserting “,
 17 subject to subparagraph (E),” after “manual
 18 medical review process that”; and

19 (B) by adding at the end the following new
 20 subparagraph:

21 “(E)(i) In place of the manual medical review process
 22 under subparagraph (C)(i), the Secretary shall implement
 23 a process for medical review under this subparagraph
 24 under which the Secretary shall identify and conduct med-
 25 ical review for services described in subparagraph (C)(i)

1 furnished by a provider of services or supplier (in this sub-
2 paragraph referred to as a ‘therapy provider’) using such
3 factors as the Secretary determines to be appropriate.

4 “(ii) Such factors may include the following:

5 “(I) The therapy provider has had a high
6 claims denial percentage for therapy services under
7 this part or is less compliant with applicable require-
8 ments under this title.

9 “(II) The therapy provider has a pattern of bill-
10 ing for therapy services under this part that is aber-
11 rant compared to peers or otherwise has question-
12 able billing practices for such services, such as bill-
13 ing medically unlikely units of services in a day.

14 “(III) The therapy provider is newly enrolled
15 under this title or has not previously furnished ther-
16 apy services under this part.

17 “(IV) The services are furnished to treat a type
18 of medical condition.

19 “(V) The therapy provider is part of group that
20 includes another therapy provider identified using
21 the factors determined under this subparagraph.

22 “(iii) For purposes of carrying out this subparagraph,
23 the Secretary shall provide for the transfer, from the Fed-
24 eral Supplementary Medical Insurance Trust Fund under
25 section 1841, of \$5,000,000 to the Centers for Medicare

1 & Medicaid Services Program Management Account for
 2 fiscal years 2015 and 2016, to remain available until ex-
 3 pended. Such funds may not be used by a contractor under
 4 section 1893(h) for medical reviews under this subpara-
 5 graph.

6 “(iv) The targeted review process under this subpara-
 7 graph shall not apply to services for which expenses are
 8 incurred beyond the period for which the exceptions proc-
 9 ess under subparagraph (A) is implemented.”.

10 (2) EFFECTIVE DATE.—The amendments made
 11 by this subsection shall apply with respect to re-
 12 quests described in section 1833(g)(5)(C)(i) of the
 13 Social Security Act (42 U.S.C. 1395l(g)(5)(C)(i))
 14 with respect to which the Secretary of Health and
 15 Human Services has not conducted medical review
 16 under such section by a date (not later than 90 days
 17 after the date of the enactment of this Act) specified
 18 by the Secretary.

19 **SEC. 203. EXTENSION OF AMBULANCE ADD-ONS.**

20 (a) GROUND AMBULANCE.—Section 1834(l)(13)(A)
 21 of the Social Security Act (42 U.S.C. 1395m(l)(13)(A))
 22 is amended by striking “April 1, 2015” and inserting
 23 “January 1, 2018” each place it appears.

24 (b) SUPER RURAL GROUND AMBULANCE.—Section
 25 1834(l)(12)(A) of the Social Security Act (42 U.S.C.

1 1395m(l)(12)(A)) is amended, in the first sentence, by
2 striking “April 1, 2015” and inserting “January 1,
3 2018”.

4 **SEC. 204. EXTENSION OF INCREASED INPATIENT HOSPITAL**
5 **PAYMENT ADJUSTMENT FOR CERTAIN LOW-**
6 **VOLUME HOSPITALS.**

7 Section 1886(d)(12) of the Social Security Act (42
8 U.S.C. 1395ww(d)(12)) is amended—

9 (1) in subparagraph (B), in the matter pre-
10 ceding clause (i), by striking “in fiscal year 2015
11 (beginning on April 1, 2015), fiscal year 2016, and
12 subsequent fiscal years” and inserting “in fiscal year
13 2018 and subsequent fiscal years”;

14 (2) in subparagraph (C)(i), by striking “fiscal
15 years 2011 through 2014 and fiscal year 2015 (be-
16 fore April 1, 2015),” and inserting “fiscal years
17 2011 through 2017,” each place it appears; and

18 (3) in subparagraph (D), by striking “fiscal
19 years 2011 through 2014 and fiscal year 2015 (be-
20 fore April 1, 2015),” and inserting “fiscal years
21 2011 through 2017,”.

1 **SEC. 205. EXTENSION OF THE MEDICARE-DEPENDENT HOS-**
2 **PITAL (MDH) PROGRAM.**

3 (a) IN GENERAL.—Section 1886(d)(5)(G) of the So-
4 cial Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amend-
5 ed—

6 (1) in clause (i), by striking “April 1, 2015”
7 and inserting “October 1, 2017”; and

8 (2) in clause (ii)(II), by striking “April 1,
9 2015” and inserting “October 1, 2017”.

10 (b) CONFORMING AMENDMENTS.—

11 (1) EXTENSION OF TARGET AMOUNT.—Section
12 1886(b)(3)(D) of the Social Security Act (42 U.S.C.
13 1395ww(b)(3)(D)) is amended—

14 (A) in the matter preceding clause (i), by
15 striking “April 1, 2015” and inserting “October
16 1, 2017”; and

17 (B) in clause (iv), by striking “through fis-
18 cal year 2014 and the portion of fiscal year
19 2015 before April 1, 2015” and inserting
20 “through fiscal year 2017”.

21 (2) PERMITTING HOSPITALS TO DECLINE RE-
22 CLASSIFICATION.—Section 13501(e)(2) of the Omni-
23 bus Budget Reconciliation Act of 1993 (42 U.S.C.
24 1395ww note) is amended by striking “through the
25 first 2 quarters of fiscal year 2015” and inserting
26 “through fiscal year 2017”.

1 **SEC. 206. EXTENSION FOR SPECIALIZED MEDICARE ADVAN-**
2 **TAGE PLANS FOR SPECIAL NEEDS INDIVID-**
3 **UALS.**

4 Section 1859(f)(1) of the Social Security Act (42
5 U.S.C. 1395w–28(f)(1)) is amended by striking “2017”
6 and inserting “2019”.

7 **SEC. 207. EXTENSION OF FUNDING FOR QUALITY MEASURE**
8 **ENDORSEMENT, INPUT, AND SELECTION.**

9 Section 1890(d)(2) of the Social Security Act (42
10 U.S.C. 1395aaa(d)(2)) is amended by striking “and
11 \$15,000,000 for the first 6 months of fiscal year 2015”
12 and inserting “and \$30,000,000 for each of fiscal years
13 2015 through 2017”.

14 **SEC. 208. EXTENSION OF FUNDING OUTREACH AND ASSIST-**
15 **ANCE FOR LOW-INCOME PROGRAMS.**

16 (a) **ADDITIONAL FUNDING FOR STATE HEALTH IN-**
17 **SURANCE PROGRAMS.**—Subsection (a)(1)(B) of section
18 119 of the Medicare Improvements for Patients and Pro-
19 viders Act of 2008 (42 U.S.C. 1395b–3 note), as amended
20 by section 3306 of the Patient Protection and Affordable
21 Care Act (Public Law 111–148), section 610 of the Amer-
22 ican Taxpayer Relief Act of 2012 (Public Law 112–240),
23 section 1110 of the Pathway for SGR Reform Act of 2013
24 (Public Law 113–67), and section 110 of the Protecting
25 Access to Medicare Act of 2014 (Public Law 113–93), is
26 amended—

- 1 (1) in clause (iv), by striking “and” at the end;
2 (2) by striking clause (v); and
3 (3) by adding at the end the following new
4 clauses:

5 “(v) for fiscal year 2015, of
6 \$7,500,000;

7 “(vi) for fiscal year 2016, of
8 \$13,000,000; and

9 “(vii) for fiscal year 2017, of
10 \$13,000,000.”.

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

- 14 (1) in clause (iv), by striking “and” at the end;
15 (2) by striking clause (v); and
16 (3) by inserting after clause (iv) the following
17 new clauses:

18 “(v) for fiscal year 2015, of
19 \$7,500,000;

20 “(vi) for fiscal year 2016, of
21 \$7,500,000; and

22 “(vii) for fiscal year 2017, of
23 \$7,500,000.”.

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

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

5 (2) by striking clause (v); and

6 (3) by inserting after clause (iv) the following
7 new clauses:

8 “(v) for fiscal year 2015, of
9 \$5,000,000;

10 “(vi) for fiscal year 2016, of
11 \$5,000,000; and

12 “(vii) for fiscal year 2017, of
13 \$5,000,000.”.

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

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

19 (2) by striking clause (v); and

20 (3) by inserting after clause (iv) the following
21 new clauses:

22 “(v) for fiscal year 2015, of
23 \$5,000,000;

24 “(vi) for fiscal year 2016, of
25 \$12,000,000; and

1 “(vii) for fiscal year 2017, of
2 \$12,000,000.”.

3 **SEC. 209. EXTENSION AND TRANSITION OF REASONABLE**
4 **COST REIMBURSEMENT CONTRACTS.**

5 (a) ONE-YEAR TRANSITION AND NOTICE REGARDING
6 TRANSITION.—Section 1876(h)(5)(C) of the Social Secu-
7 rity Act (42 U.S.C. 1395mm(h)(5)(C)) is amended—

8 (1) in clause (ii), in the matter preceding sub-
9 clause (I), by striking “For any” and inserting
10 “Subject to clause (iv), for any”;

11 (2) in clause (iii)(I), by inserting “cost plan
12 service” after “With respect to any portion of the”;

13 (3) in clause (iii)(II), by inserting “cost plan
14 service” after “With respect to any other portion of
15 such”; and

16 (4) by adding at the end the following new
17 clauses:

18 “(iv) In the case of an eligible organization that is
19 offering a reasonable cost reimbursement contract that
20 may no longer be extended or renewed because of the ap-
21 plication of clause (ii), or where such contract has been
22 extended or renewed but the eligible organization has in-
23 formed the Secretary in writing not later than a date de-
24 termined appropriate by the Secretary that such organiza-

1 tion voluntarily plans not to seek renewal of the reasonable
2 cost reimbursement contract, the following shall apply:

3 “(I) Notwithstanding such clause, such contract
4 may be extended or renewed for the two years subse-
5 quent to 2016. The final year in which such contract
6 is extended or renewed is referred to in this sub-
7 section as the ‘last reasonable cost reimbursement
8 contract year for the contract’.

9 “(II) The organization may not enroll a new en-
10 rollee under such contract during the last reasonable
11 cost reimbursement contract year for the contract
12 (but may continue to enroll new enrollees through
13 the end of the year immediately preceding such
14 year) unless such enrollee is any of the following:

15 “(aa) An individual who chooses enroll-
16 ment in the reasonable cost contract during the
17 annual election period with respect to such last
18 year.

19 “(bb) An individual whose spouse, at the
20 time of the individual’s enrollment is an enrollee
21 under the reasonable cost reimbursement con-
22 tract.

23 “(cc) An individual who is covered under
24 an employer group health plan that offers cov-

1 erage through the reasonable cost reimburse-
2 ment contract.

3 “(dd) An individual who becomes entitled
4 to benefits under part A, or enrolled under part
5 B, and was enrolled in a plan offered by the eli-
6 gible organization immediately prior to the indi-
7 vidual’s enrollment under the reasonable cost
8 reimbursement contract.

9 “(III) Not later than a date determined appro-
10 prium by the Secretary prior to the beginning of the
11 last reasonable cost reimbursement contract year for
12 the contract, the organization shall provide notice to
13 the Secretary as to whether the organization will
14 apply to have the contract converted over, in whole
15 or in part, and offered as a Medicare Advantage
16 plan under part C for the year following the last rea-
17 sonable cost reimbursement contract year for the
18 contract.

19 “(IV) If the organization provides the notice de-
20 scribed in subclause (III) that the contract will be
21 converted, in whole or in part, the organization
22 shall, not later than a date determined appropriate
23 by the Secretary, provide the Secretary with such in-
24 formation as the Secretary determines appropriate
25 in order to carry out section 1851(c)(4) and to carry

1 out section 1854(a)(5), including subparagraph
2 (C)(ii) of such section.

3 “(V) In the case that the organization enrolls a
4 new enrollee under such contract during the last rea-
5 sonable cost reimbursement contract year for the
6 contract, the organization shall provide the indi-
7 vidual with a notification that such year is the last
8 year for such contract.

9 “(v) If an eligible organization that is offering a rea-
10 sonable cost reimbursement contract that is extended or
11 renewed pursuant to clause (iv) provides the notice de-
12 scribed in clause (iv)(III) that the contract will be con-
13 verted, in whole or in part, the following shall apply:

14 “(I) The deemed enrollment under section
15 1851(c)(4).

16 “(II) The special rule for quality increase under
17 section 1853(o)(4)(C).

18 “(III) During the last reasonable cost reim-
19 bursement contract year for the contract and the
20 year immediately preceding such year, the eligible
21 organization, or the corporate parent organization of
22 the eligible organization, shall be permitted to offer
23 an MA plan in the area that such contract is being
24 offered and enroll Medicare Advantage eligible indi-
25 viduals in such MA plan and such cost plan.”.

1 (b) DEEMED ENROLLMENT FROM REASONABLE
 2 COST REIMBURSEMENT CONTRACTS CONVERTED TO
 3 MEDICARE ADVANTAGE PLANS.—

4 (1) IN GENERAL.—Section 1851(c) of the So-
 5 cial Security Act (42 U.S.C. 1395w-21(c)) is
 6 amended—

7 (A) in paragraph (1), by striking “Such
 8 elections” and inserting “Subject to paragraph
 9 (4), such elections”; and

10 (B) by adding at the end the following:

11 “(4) DEEMED ENROLLMENT RELATING TO CON-
 12 VERTED REASONABLE COST REIMBURSEMENT CON-
 13 TRACTS.—

14 “(A) IN GENERAL.—On the first day of
 15 the annual, coordinated election period under
 16 subsection (e)(3) for plan years beginning on or
 17 after January 1, 2017, an MA eligible indi-
 18 vidual described in clause (i) or (ii) of subpara-
 19 graph (B) is deemed, unless the individual
 20 elects otherwise, to have elected to receive bene-
 21 fits under this title through an applicable MA
 22 plan (and shall be enrolled in such plan) begin-
 23 ning with such plan year, if—

1 “(i) the individual is enrolled in a rea-
2 sonable cost reimbursement contract under
3 section 1876(h) in the previous plan year;

4 “(ii) such reasonable cost reimburse-
5 ment contract was extended or renewed for
6 the last reasonable cost reimbursement
7 contract year of the contract (as described
8 in subclause (I) of section
9 1876(h)(5)(C)(iv)) pursuant to such sec-
10 tion;

11 “(iii) the eligible organization that is
12 offering such reasonable cost reimburse-
13 ment contract provided the notice de-
14 scribed in subclause (III) of such section
15 that the contract was to be converted;

16 “(iv) the applicable MA plan—

17 “(I) is the plan that was con-
18 verted from the reasonable cost reim-
19 bursement contract described in
20 clause (iii);

21 “(II) is offered by the same enti-
22 ty (or an organization affiliated with
23 such entity that has a common owner-
24 ship interest of control) that entered
25 into such contract; and

1 “(III) is offered in the service
2 area where the individual resides;

3 “(v) in the case of reasonable cost re-
4 imbursement contracts that provide cov-
5 erage under parts A and B (and, to the ex-
6 tent the Secretary determines it to be fea-
7 sible, contracts that provide only part B
8 coverage), the difference between the esti-
9 mated premiums (and other individuals
10 costs as determined applicable by the Sec-
11 retary) for the applicable MA plan and the
12 estimated premiums (and such costs) for
13 the predecessor cost plan does not exceed
14 a threshold established by the Secretary;
15 and

16 “(vi) the applicable MA plan—

17 “(I) provides coverage for enroll-
18 ees transitioning from the converted
19 reasonable cost reimbursement con-
20 tract to such plan to maintain current
21 providers of services and suppliers
22 and course of treatment at the time of
23 enrollment for a period of at least 90
24 days after enrollment; and

1 “(II) during such period, pays
2 such providers of services and sup-
3 pliers for items and services furnished
4 to the enrollee an amount that is not
5 less than the amount of payment ap-
6 plicable for such items and services
7 under the original Medicare fee-for-
8 service program under parts A and B.

9 “(B) MA ELIGIBLE INDIVIDUALS DE-
10 SCRIBED.—

11 “(i) WITHOUT PRESCRIPTION DRUG
12 COVERAGE.—An MA eligible individual de-
13 scribed in this clause, with respect to a
14 plan year, is an MA eligible individual who
15 is enrolled in a reasonable cost reimburse-
16 ment contract under section 1876(h) in the
17 previous plan year and who is not, for such
18 previous plan year, enrolled in a prescrip-
19 tion drug plan under part D, including
20 coverage under section 1860D–22.

21 “(ii) WITH PRESCRIPTION DRUG COV-
22 ERAGE.—An MA eligible individual de-
23 scribed in this clause, with respect to a
24 plan year, is an MA eligible individual who
25 is enrolled in a reasonable cost reimburse-

1 ment contract under section 1876(h) in the
 2 previous plan year and who, for such pre-
 3 vious plan year, is enrolled in a prescrip-
 4 tion drug plan under part D—

5 “(I) through such contract; or

6 “(II) through a prescription drug
 7 plan, if the sponsor of such plan is the
 8 same entity (or an organization affili-
 9 ated with such entity) that entered
 10 into such contract.

11 “(C) APPLICABLE MA PLAN DEFINED.—In
 12 this paragraph, the term ‘applicable MA plan’
 13 means, in the case of an individual described
 14 in—

15 “(i) subparagraph (B)(i), an MA plan
 16 that is not an MA–PD plan; and

17 “(ii) subparagraph (B)(ii), an MA–
 18 PD plan.

19 “(D) IDENTIFICATION AND NOTIFICATION
 20 OF DEEMED INDIVIDUALS.—Not later than 45
 21 days before the first day of the annual, coordi-
 22 nated election period under subsection (e)(3)
 23 for plan years beginning on or after January 1,
 24 2017, the Secretary shall identify and notify the
 25 individuals who will be subject to deemed elec-

1 tions under subparagraph (A) on the first day
2 of such period.”.

3 (2) BENEFICIARY OPTION TO DISCONTINUE OR
4 CHANGE MA PLAN OR MA–PD PLAN AFTER DEEMED
5 ENROLLMENT.—

6 (A) IN GENERAL.—Section 1851(e)(2) of
7 the Social Security Act (42 U.S.C. 1395w–
8 21(e)(4)) is amended by adding at the end the
9 following:

10 “(F) SPECIAL PERIOD FOR CERTAIN
11 DEEMED ELECTIONS.—

12 “(i) IN GENERAL.—At any time dur-
13 ing the period beginning after the last day
14 of the annual, coordinated election period
15 under paragraph (3) in which an individual
16 is deemed to have elected to enroll in an
17 MA plan or MA–PD plan under subsection
18 (c)(4) and ending on the last day of Feb-
19 ruary of the first plan year for which the
20 individual is enrolled in such plan, such in-
21 dividual may change the election under
22 subsection (a)(1) (including changing the
23 MA plan or MA–PD plan in which the in-
24 dividual is enrolled).

1 “(ii) LIMITATION OF ONE CHANGE.—
 2 An individual may exercise the right under
 3 clause (i) only once during the applicable
 4 period described in such clause. The limita-
 5 tion under this clause shall not apply to
 6 changes in elections effected during an an-
 7 nual, coordinated election period under
 8 paragraph (3) or during a special enroll-
 9 ment period under paragraph (4).”.

10 (B) CONFORMING AMENDMENTS.—

11 (i) PLAN REQUIREMENT FOR OPEN
 12 ENROLLMENT.—Section 1851(e)(6)(A) of
 13 the Social Security Act (42 U.S.C. 1395w-
 14 21(e)(6)(A)) is amended by striking “para-
 15 graph (1),” and inserting “paragraph (1),
 16 during the period described in paragraph
 17 (2)(F),”.

18 (ii) PART D.—Section 1860D-
 19 1(b)(1)(B) of such Act (42 U.S.C. 1395w-
 20 101(b)(1)(B)) is amended—

21 (I) in clause (ii), by adding “and
 22 paragraph (4)” after “paragraph
 23 (3)(A)”; and

1 (II) in clause (iii) by striking
2 “and (E)” and inserting “(E), and
3 (F)”.

4 (3) TREATMENT OF ESRD FOR DEEMED EN-
5 ROLLMENT.—Section 1851(a)(3)(B) of the Social
6 Security Act (42 U.S.C. 1395w–21(a)(3)(B)) is
7 amended by adding at the end the following flush
8 sentence: “An individual who develops end-stage
9 renal disease while enrolled in a reasonable cost re-
10 imbursement contract under section 1876(h) shall be
11 treated as an MA eligible individual for purposes of
12 applying the deemed enrollment under subsection
13 (c)(4).”.

14 (c) INFORMATION REQUIREMENTS.—Section
15 1851(d)(2)(B) of the Social Security Act (42 U.S.C.
16 1395w–21(d)(2)(B)) is amended—

17 (1) in the heading, by striking “NOTIFICATION
18 TO NEWLY ELIGIBLE MEDICARE ADVANTAGE ELIGI-
19 BLE INDIVIDUALS” and inserting the following: “No-
20 TIFICATIONS REQUIRED.—

21 “(i) NOTIFICATION TO NEWLY ELIGI-
22 BLE MEDICARE ADVANTAGE ELIGIBLE IN-
23 DIVIDUALS.—”; and

24 (2) by adding at the end the following new
25 clause:

1 “(ii) NOTIFICATION RELATED TO CER-
2 TAIN DEEMED ELECTIONS.—The Secretary
3 shall require a Medicare Advantage organi-
4 zation that is offering a Medicare Advan-
5 tage plan that has been converted from a
6 reasonable cost reimbursement contract
7 pursuant to section 1876(h)(5)(C)(iv) to
8 mail, not later than 30 days prior to the
9 first day of the annual, coordinated elec-
10 tion period under subsection (e)(3) of a
11 year, to any individual enrolled under such
12 contract and identified by the Secretary
13 under subsection (c)(4)(D) for such year—

14 “(I) a notification that such indi-
15 vidual will, on such day, be deemed to
16 have made an election with respect to
17 such plan to receive benefits under
18 this title through an MA plan or MA-
19 PD plan (and shall be enrolled in such
20 plan) for the next plan year under
21 subsection (c)(4)(A), but that the in-
22 dividual may make a different election
23 during the annual, coordinated elec-
24 tion period for such year;

1 “(II) the information described in
2 subparagraph (A);

3 “(III) a description of the dif-
4 ferences between such MA plan or
5 MA–PD plan and the reasonable cost
6 reimbursement contract in which the
7 individual was most recently enrolled
8 with respect to benefits covered under
9 such plans, including cost-sharing,
10 premiums, drug coverage, and pro-
11 vider networks;

12 “(IV) information about the spe-
13 cial period for elections under sub-
14 section (e)(2)(F); and

15 “(V) other information the Sec-
16 retary may specify.”.

17 (d) TREATMENT OF TRANSITION PLAN FOR QUALITY
18 RATING FOR PAYMENT PURPOSES.—Section 1853(o)(4)
19 of the Social Security Act (42 U.S.C. 1395w–23(o)(4)) is
20 amended by adding at the end the following new subpara-
21 graph:

22 “(C) SPECIAL RULE FOR FIRST 3 PLAN
23 YEARS FOR PLANS THAT WERE CONVERTED
24 FROM A REASONABLE COST REIMBURSEMENT
25 CONTRACT.—For purposes of applying para-

graph (1) and section 1854(b)(1)(C) for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1851(c)(4)—

“(i) such plan shall not be treated as a new MA plan (as defined in paragraph (3)(A)(iii)(II)); and

“(ii) in determining the star rating of the plan under subparagraph (A), to the extent that Medicare Advantage data for such plan is not available for a measure used to determine such star rating, the Secretary shall use data from the period in which such plan was a reasonable cost reimbursement contract.”.

SEC. 210. EXTENSION OF HOME HEALTH RURAL ADD-ON.

Section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283; 42 U.S.C. 1395fff note), as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 46) and by section 3131(c) of the Patient Protection and Affordable Care Act (Public Law 111–148; 124 Stat. 428), is amended by striking “January 1, 2016” and inserting “January 1, 2018” each place it appears.

Subtitle B—Other Health Extenders

SEC. 211. PERMANENT EXTENSION OF THE QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) PERMANENT EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking “(but only for premiums payable with respect to months during the period beginning with January 1998, and ending with March 2015)”.

(b) ALLOCATIONS.—Section 1933(g) of the Social Security Act (42 U.S.C. 1396u–3(g)) is amended—

(1) in paragraph (2)—

(A) by striking subparagraphs (A) through (H);

(B) in subparagraph (V), by striking “and” at the end;

(C) in subparagraph (W), by striking the period at the end and inserting a semicolon;

(D) by redesignating subparagraphs (I) through (W) as subparagraphs (A) through (O), respectively; and

(E) by adding at the end the following new subparagraphs:

1 “(P) for the period that begins on April 1,
2 2015, and ends on December 31, 2015, the
3 total allocation amount is \$535,000,000; and

4 “(Q) for 2016 and, subject to paragraph
5 (4), for each subsequent year, the total alloca-
6 tion amount is \$980,000,000.”;

7 (2) in paragraph (3), by striking “(P), (R), (T),
8 or (V)” and inserting “or (P)”; and

9 (3) by adding at the end the following new
10 paragraph:

11 “(4) ADJUSTMENT TO ALLOCATIONS.—The
12 Secretary may increase the allocation amount under
13 paragraph (2)(Q) for a year (beginning with 2017)
14 up to an amount that does not exceed the product
15 of the following:

16 “(A) MAXIMUM ALLOCATION AMOUNT FOR
17 PREVIOUS YEAR.—In the case of 2017, the allo-
18 cation amount for 2016, or in the case of a sub-
19 sequent year, the maximum allocation amount
20 allowed under this paragraph for the previous
21 year.

22 “(B) INCREASE IN PART B PREMIUM.—
23 The monthly premium rate determined under
24 section 1839 for the year divided by the month-

1 ly premium rate determined under such section
 2 for the previous year.

3 “(C) INCREASE IN PART B ENROLL-
 4 MENT.—The average number of individuals (as
 5 estimated by the Chief Actuary of the Centers
 6 for Medicare & Medicaid Services in September
 7 of the previous year) to be enrolled under part
 8 B of title XVIII for months in the year divided
 9 by the average number of such individuals (as
 10 so estimated) under this subparagraph with re-
 11 spect to enrollments in months in the previous
 12 year.”.

13 **SEC. 212. PERMANENT EXTENSION OF TRANSITIONAL MED-**
 14 **ICAL ASSISTANCE (TMA).**

15 (a) IN GENERAL.—Section 1925 of the Social Secu-
 16 rity Act (42 U.S.C. 1396r–6) is amended—

17 (1) by striking subsection (f); and

18 (2) by redesignating subsection (g) as sub-
 19 section (f).

20 (b) CONFORMING AMENDMENT.—Section 1902(e)(1)
 21 of the Social Security Act (42 U.S.C. 1396a(e)(1)) is
 22 amended to read as follows:

23 “(1) Beginning April 1, 1990, for provisions relating
 24 to the extension of eligibility for medical assistance for cer-
 25 tain families who have received aid pursuant to a State

1 plan approved under part A of title IV and have earned
2 income, see section 1925.”.

3 **SEC. 213. EXTENSION OF SPECIAL DIABETES PROGRAM**
4 **FOR TYPE I DIABETES AND FOR INDIANS.**

5 (a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-
6 BETES.—Section 330B(b)(2)(C) of the Public Health
7 Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by
8 striking “2015” and inserting “2017”.

9 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—
10 Section 330C(c)(2)(C) of the Public Health Service Act
11 (42 U.S.C. 254c–3(c)(2)(C)) is amended by striking
12 “2015” and inserting “2017”.

13 **SEC. 214. EXTENSION OF ABSTINENCE EDUCATION.**

14 (a) IN GENERAL.—Section 510 of the Social Security
15 Act (42 U.S.C. 710) is amended—

16 (1) in subsection (a), striking “2015” and in-
17 serting “2017”; and

18 (2) in subsection (d), by inserting “and an ad-
19 ditional \$75,000,000 for each of fiscal years 2016
20 and 2017” after “2015”.

21 (b) BUDGET SCORING.—Notwithstanding section
22 257(b)(2) of the Balanced Budget and Emergency Deficit
23 Control Act of 1985, the baseline shall be calculated as-
24 suming that no grant shall be made under section 510

1 of the Social Security Act (42 U.S.C. 710) after fiscal year
2 2017.

3 (c) REALLOCATION OF UNUSED FUNDING.—The re-
4 maining unobligated balances of the amount appropriated
5 for fiscal years 2016 and 2017 by section 510(d) of the
6 Social Security Act (42 U.S.C. 710(d)) for which no appli-
7 cation has been received by the Funding Opportunity An-
8 nouncement deadline, shall be made available to States
9 that require the implementation of each element described
10 in subparagraphs (A) through (H) of the definition of ab-
11 stinence education in section 510(b)(2). The remaining
12 unobligated balances shall be reallocated to such States
13 that submit a valid application consistent with the original
14 formula for this funding.

15 **SEC. 215. EXTENSION OF PERSONAL RESPONSIBILITY EDU-**
16 **CATION PROGRAM (PREP).**

17 Section 513 of the Social Security Act (42 U.S.C.
18 713) is amended—

19 (1) in paragraphs (1)(A) and (4)(A) of sub-
20 section (a), by striking “2015” and inserting
21 “2017” each place it appears;

22 (2) in subsection (a)(4)(B)(i), by striking “,
23 2013, 2014, and 2015” and inserting “through
24 2017”; and

1 (3) in subsection (f), by striking “2015” and
2 inserting “2017”.

3 **SEC. 216. EXTENSION OF FUNDING FOR FAMILY-TO-FAMILY**
4 **HEALTH INFORMATION CENTERS.**

5 Section 501(c)(1)(A) of the Social Security Act (42
6 U.S.C. 701(c)(1)(A)) is amended—

7 (1) by striking clause (vi); and

8 (2) by adding after clause (v) the following new
9 clause:

10 “(vi) \$5,000,000 for each of fiscal years 2015
11 through 2017.”.

12 **SEC. 217. EXTENSION OF HEALTH WORKFORCE DEM-**
13 **ONSTRATION PROJECT FOR LOW-INCOME IN-**
14 **DIVIDUALS.**

15 Section 2008(c)(1) of the Social Security Act (42
16 U.S.C. 1397g(c)(1)) is amended by striking “2015” and
17 inserting “2017”.

18 **SEC. 218. EXTENSION OF MATERNAL, INFANT, AND EARLY**
19 **CHILDHOOD HOME VISITING PROGRAMS.**

20 Section 511(j)(1) of the Social Security Act (42
21 U.S.C. 711(j)) is amended—

22 (1) by striking “and” at the end of subpara-
23 graph (E);

24 (2) in subparagraph (F)—

1 (A) by striking “for the period beginning
2 on October 1, 2014, and ending on March 31,
3 2015” and inserting “for fiscal year 2015”;

4 (B) by striking “an amount equal to the
5 amount provided in subparagraph (E)” and in-
6 serting “\$400,000,000”; and

7 (C) by striking the period at the end and
8 inserting a semicolon; and

9 (3) by adding at the end the following new sub-
10 paragraphs:

11 “(G) for fiscal year 2016, \$400,000,000;
12 and

13 “(H) for fiscal year 2017, \$400,000,000.”.

14 **SEC. 219. TENNESSEE DSH ALLOTMENT FOR FISCAL YEARS**
15 **2015 THROUGH 2025.**

16 Section 1923(f)(6)(A) of the Social Security Act (42
17 U.S.C. 1396r-4(f)(6)(A)) is amended by adding at the end
18 the following:

19 “(vi) ALLOTMENT FOR FISCAL YEARS
20 2015 THROUGH 2025.—Notwithstanding any
21 other provision of this subsection, any
22 other provision of law, or the terms of the
23 TennCare Demonstration Project in effect
24 for the State, the DSH allotment for Ten-
25 nessee for fiscal year 2015, and for each

1 fiscal year thereafter through fiscal year
 2 2025, shall be \$53,100,000 for each such
 3 fiscal year.”.

4 **SEC. 220. DELAY IN EFFECTIVE DATE FOR MEDICAID**
 5 **AMENDMENTS RELATING TO BENEFICIARY**
 6 **LIABILITY SETTLEMENTS.**

7 Section 202(c) of the Bipartisan Budget Act of 2013
 8 (division A of Public Law 113–67; 42 U.S.C. 1396a note),
 9 as amended by section 211 of the Protecting Access to
 10 Medicare Act of 2014 (Public Law 113–93; 128 Stat.
 11 1047) is amended by striking “October 1, 2016” and in-
 12 serting “October 1, 2017”.

13 **SEC. 221. EXTENSION OF FUNDING FOR COMMUNITY**
 14 **HEALTH CENTERS, THE NATIONAL HEALTH**
 15 **SERVICE CORPS, AND TEACHING HEALTH**
 16 **CENTERS.**

17 (a) FUNDING FOR COMMUNITY HEALTH CENTERS
 18 AND THE NATIONAL HEALTH SERVICE CORPS.—

19 (1) COMMUNITY HEALTH CENTERS.—Section
 20 10503(b)(1)(E) of the Patient Protection and Af-
 21 fordable Care Act (42 U.S.C. 254b–2(b)(1)(E)) is
 22 amended by striking “for fiscal year 2015” and in-
 23 serting “for each of fiscal years 2015 through
 24 2017”.

1 (2) NATIONAL HEALTH SERVICE CORPS.—Sec-
 2 tion 10503(b)(2)(E) of the Patient Protection and
 3 Affordable Care Act (42 U.S.C. 254b–2(b)(2)(E)) is
 4 amended by striking “for fiscal year 2015” and in-
 5 serting “for each of fiscal years 2015 through
 6 2017”.

7 (b) EXTENSION OF TEACHING HEALTH CENTERS
 8 PROGRAM.—Section 340H(g) of the Public Health Service
 9 Act (42 U.S.C. 256h(g)) is amended by inserting “and
 10 \$60,000,000 for each of fiscal years 2016 and 2017” be-
 11 fore the period at the end.

12 (c) APPLICATION.—Amounts appropriated pursuant
 13 to this section for fiscal year 2016 and fiscal year 2017
 14 are subject to the requirements contained in Public Law
 15 113–235 for funds for programs authorized under sections
 16 330 through 340 of the Public Health Service Act (42
 17 U.S.C. 254b–256).

18 **TITLE III—CHIP**

19 **SEC. 301. 2-YEAR EXTENSION OF THE CHILDREN’S HEALTH** 20 **INSURANCE PROGRAM.**

21 (a) FUNDING.—Section 2104(a) of the Social Secu-
 22 rity Act (42 U.S.C. 1397dd(a)) is amended—

23 (1) in paragraph (17), by striking “and” at the
 24 end;

1 (2) in paragraph (18)(B), by striking the period
2 at the end and inserting a semicolon; and

3 (3) by adding at the end the following new
4 paragraphs:

5 “(19) for fiscal year 2016, \$19,300,000,000;
6 and

7 “(20) for fiscal year 2017, for purposes of mak-
8 ing 2 semi-annual allotments—

9 “(A) \$2,850,000,000 for the period begin-
10 ning on October 1, 2016, and ending on March
11 31, 2017; and

12 “(B) \$2,850,000,000 for the period begin-
13 ning on April 1, 2017, and ending on Sep-
14 tember 30, 2017.”.

15 (b) ALLOTMENTS.—

16 (1) IN GENERAL.—Section 2104(m) of the So-
17 cial Security Act (42 U.S.C. 1397dd(m)) is amend-
18 ed—

19 (A) in the subsection heading, by striking
20 “THROUGH 2015” and inserting “AND THERE-
21 AFTER”;

22 (B) in paragraph (2)—

23 (i) in the paragraph heading, by strik-
24 ing “2014” and inserting “2016”; and

1 (ii) by striking subparagraph (B) and
2 inserting the following new subparagraph:

3 “(B) FISCAL YEAR 2013 AND EACH SUC-
4 CEEDING FISCAL YEAR.—Subject to paragraphs
5 (5) and (7), from the amount made available
6 under paragraphs (16) through (19) of sub-
7 section (a) for fiscal year 2013 and each suc-
8 ceeding fiscal year, respectively, the Secretary
9 shall compute a State allotment for each State
10 (including the District of Columbia and each
11 commonwealth and territory) for each such fis-
12 cal year as follows:

13 “(i) REBASING IN FISCAL YEAR 2013
14 AND EACH SUCCEEDING ODD-NUMBERED
15 FISCAL YEAR.—For fiscal year 2013 and
16 each succeeding odd-numbered fiscal year
17 (other than fiscal years 2015 and 2017),
18 the allotment of the State is equal to the
19 Federal payments to the State that are at-
20 tributable to (and countable toward) the
21 total amount of allotments available under
22 this section to the State in the preceding
23 fiscal year (including payments made to
24 the State under subsection (n) for such
25 preceding fiscal year as well as amounts

1 redistributed to the State in such pre-
2 ceding fiscal year), multiplied by the allot-
3 ment increase factor under paragraph (6)
4 for such odd-numbered fiscal year.

5 “(ii) GROWTH FACTOR UPDATE FOR
6 FISCAL YEAR 2014 AND EACH SUCCEEDING
7 EVEN-NUMBERED FISCAL YEAR.—Except
8 as provided in clauses (iii) and (iv), for fis-
9 cal year 2014 and each succeeding even-
10 numbered fiscal year, the allotment of the
11 State is equal to the sum of—

12 “(I) the amount of the State al-
13 lotment under clause (i) for the pre-
14 ceding fiscal year; and

15 “(II) the amount of any pay-
16 ments made to the State under sub-
17 section (n) for such preceding fiscal
18 year,
19 multiplied by the allotment increase factor
20 under paragraph (6) for such even-num-
21 bered fiscal year.

22 “(iii) SPECIAL RULE FOR 2016.—For
23 fiscal year 2016, the allotment of the State
24 is equal to the Federal payments to the
25 State that are attributable to (and count-

1 able toward) the total amount of allot-
2 ments available under this section to the
3 State in the preceding fiscal year (includ-
4 ing payments made to the State under
5 subsection (n) for such preceding fiscal
6 year as well as amounts redistributed to
7 the State in such preceding fiscal year),
8 but determined as if the last two sentences
9 of section 2105(b) were in effect in such
10 preceding fiscal year and then multiplying
11 the result by the allotment increase factor
12 under paragraph (6) for fiscal year 2016.

13 “(iv) REDUCTION IN 2018.—For fiscal
14 year 2018, with respect to the allotment of
15 the State for fiscal year 2017, any
16 amounts of such allotment that remain
17 available for expenditure by the State in
18 fiscal year 2018 shall be reduced by one-
19 third.”;

20 (C) in paragraph (4), by inserting “or
21 2017” after “2015”;

22 (D) in paragraph (6)—

23 (i) in subparagraph (A), by striking
24 “2015” and inserting “2017”; and

1 (ii) in the second sentence, by striking
 2 “or fiscal year 2014” and inserting “fiscal
 3 year 2014, or fiscal year 2016”;

4 (E) in paragraph (8)—

5 (i) in the paragraph heading, by strik-
 6 ing “FISCAL YEAR 2015” and inserting
 7 “FISCAL YEARS 2015 AND 2017”; and

8 (ii) by inserting “or fiscal year 2017”
 9 after “2015”;

10 (F) by redesignating paragraphs (4)
 11 through (8) as paragraphs (5) through (9), re-
 12 spectively; and

13 (G) by inserting after paragraph (3) the
 14 following new paragraph:

15 “(4) FOR FISCAL YEAR 2017.—

16 “(A) FIRST HALF.—Subject to paragraphs
 17 (5) and (7), from the amount made available
 18 under subparagraph (A) of paragraph (20) of
 19 subsection (a) for the semi-annual period de-
 20 scribed in such paragraph, increased by the
 21 amount of the appropriation for such period
 22 under section 301(b)(2) of the Medicare Access
 23 and CHIP Reauthorization Act of 2015, the
 24 Secretary shall compute a State allotment for
 25 each State (including the District of Columbia

1 and each commonwealth and territory) for such
 2 semi-annual period in an amount equal to the
 3 first half ratio (described in subparagraph (D))
 4 of the amount described in subparagraph (C).

5 “(B) SECOND HALF.—Subject to para-
 6 graphs (5) and (7), from the amount made
 7 available under subparagraph (B) of paragraph
 8 (20) of subsection (a) for the semi-annual pe-
 9 riod described in such paragraph, the Secretary
 10 shall compute a State allotment for each State
 11 (including the District of Columbia and each
 12 commonwealth and territory) for such semi-an-
 13 nual period in an amount equal to the amount
 14 made available under such subparagraph, multi-
 15 plied by the ratio of—

16 “(i) the amount of the allotment to
 17 such State under subparagraph (A); to

18 “(ii) the total of the amount of all of
 19 the allotments made available under such
 20 subparagraph.

21 “(C) FULL YEAR AMOUNT BASED ON
 22 REBASED AMOUNT.—The amount described in
 23 this subparagraph for a State is equal to the
 24 Federal payments to the State that are attrib-
 25 utable to (and countable towards) the total

1 amount of allotments available under this sec-
 2 tion to the State in fiscal year 2016 (including
 3 payments made to the State under subsection
 4 (n) for fiscal year 2016 as well as amounts re-
 5 distributed to the State in fiscal year 2016),
 6 multiplied by the allotment increase factor
 7 under paragraph (6) for fiscal year 2017.

8 “(D) FIRST HALF RATIO.—The first half
 9 ratio described in this subparagraph is the ratio
 10 of—

11 “(i) the sum of—

12 “(I) the amount made available
 13 under subsection (a)(20)(A); and

14 “(II) the amount of the appro-
 15 priation for such period under section
 16 301(b)(2) of the Medicare Access and
 17 CHIP Reauthorization Act of 2015;
 18 to

19 “(ii) the sum of the—

20 “(I) amount described in clause
 21 (i); and

22 “(II) the amount made available
 23 under subsection (a)(20)(B).”.

24 (2) CONFORMING AMENDMENTS.—

1 (A) Section 2104(c)(1) of the Social Secu-
2 rity Act (42 U.S.C. 1397dd(c)(1)) is amended
3 by striking “(m)(4)” and inserting “(m)(5)”.

4 (B) Section 2104(m) of such Act (42
5 U.S.C. 1397dd(m)), as amended by paragraph
6 (1), is further amended—

7 (i) by striking “the allotment increase
8 factor determined under paragraph (5)”
9 each place it appears in paragraphs (1)
10 (2)(A), and (3) and inserting “the allot-
11 ment increase factor determined under
12 paragraph (6)”;

13 (ii) in paragraph (1)—

14 (I) by striking “paragraph (4)”
15 each place it appears in subpara-
16 graphs (A) and (B) and inserting
17 “paragraph (5)”;

18 (II) by striking “the allotment
19 increase factor determined under
20 paragraph (5)” each place it appears
21 and inserting “the allotment increase
22 factor determined under paragraph
23 (6)”;

24 (iii) in paragraph (2)(A), by striking
25 “the allotment increase factor under para-

graph (5)” and inserting “the allotment increase factor under paragraph (6)”;

(iv) in paragraph (3)—

(I) by striking “paragraphs (4) and (6)” and inserting “paragraphs (5) and (7)”;

(II) by striking “the allotment increase factor under paragraph (5)” and inserting “the allotment increase factor under paragraph (6)”;

(v) in paragraph (5) (as redesignated by paragraph (1)(F)), by striking “paragraph (1), (2), or (3)” and inserting “paragraph (1), (2), (3), or (4)”;

(vi) in paragraph (7) (as redesignated by paragraph (1)(F)), by striking “subject to paragraph (4)” and inserting “subject to paragraph (5)”;

(vii) in paragraph (9), (as redesignated by paragraph (1)(F)), by striking “paragraph (3)” and inserting “paragraph (3) or (4)”.

(C) Section 2104(n)(3)(B)(ii) of such Act (42 U.S.C. 1397dd(n)(3)(B)(ii)) is amended by

1 striking “subsection (m)(5)(B)” and inserting
2 “subsection (m)(6)(B)”.

3 (D) Section 2111(b)(2)(B)(i) of such Act
4 (42 U.S.C. 1397kk(b)(2)(B)(i)) is amended by
5 striking “section 2104(m)(4)” and inserting
6 “section 2104(m)(5)”.

7 (3) ONE-TIME APPROPRIATION FOR FISCAL
8 YEAR 2017.—There is appropriated to the Secretary
9 of Health and Human Services, out of any money in
10 the Treasury not otherwise appropriated,
11 \$14,700,000,000 to accompany the allotment made
12 for the period beginning on October 1, 2016, and
13 ending on March 31, 2017, under paragraph
14 (20)(A) of section 2104(a) of the Social Security Act
15 (42 U.S.C. 1397dd(a)) (as added by subsection
16 (a)(1)), to remain available until expended. Such
17 amount shall be used to provide allotments to States
18 under paragraph (3) of section 2104(m) of such Act
19 (42 U.S.C. 1397dd(m)) (as amended by paragraph
20 (1)(C)) for the first 6 months of fiscal year 2017 in
21 the same manner as allotments are provided under
22 subsection (a)(20)(A) of such section 2104 and sub-
23 ject to the same terms and conditions as apply to
24 the allotments provided from such subsection
25 (a)(20)(A).

1 (c) EXTENSION OF QUALIFYING STATES OPTION.—

2 Section 2105(g)(4) of the Social Security Act (42 U.S.C.

3 1397ee(g)(4)) is amended—

4 (1) in the paragraph heading, by striking

5 “2015” and inserting “2017”; and

6 (2) in subparagraph (A), by striking “2015”

7 and inserting “2017”.

8 (d) EXTENSION OF THE CHILD ENROLLMENT CON-

9 TINGENCY FUND.—

10 (1) IN GENERAL.—Section 2104(n) of the So-

11 cial Security Act (42 U.S.C. 1397dd(n)) is amend-

12 ed—

13 (A) in paragraph (2)—

14 (i) in subparagraph (A)(ii)—

15 (I) by striking “2010 through

16 2014” and inserting “2010, 2011,

17 2012, 2013, 2014, and 2016”; and

18 (II) by inserting “and 2017”

19 after “2015”; and

20 (ii) in subparagraph (B)—

21 (I) by striking “2010 through

22 2014” and inserting “2010, 2011,

23 2012, 2013, 2014, and 2016”; and

24 (II) by inserting “and 2017”

25 after “2015”; and

1 (B) in paragraph (3)(A), in the matter
2 preceding clause (i), by striking “fiscal year
3 2009, fiscal year 2010, fiscal year 2011, fiscal
4 year 2012, fiscal year 2013, fiscal year 2014, or
5 a semi-annual allotment period for fiscal year
6 2015” and inserting “any of fiscal years 2009
7 through 2014, fiscal year 2016, or a semi-an-
8 nual allotment period for fiscal year 2015 or
9 2017”.

10 **SEC. 302. EXTENSION OF EXPRESS LANE ELIGIBILITY.**

11 Section 1902(e)(13)(I) of the Social Security Act (42
12 U.S.C. 1396a(e)(13)(I)) is amended by striking “2015”
13 and inserting “2017”.

14 **SEC. 303. EXTENSION OF OUTREACH AND ENROLLMENT**
15 **PROGRAM.**

16 Section 2113 of the Social Security Act (42 U.S.C.
17 1397mm) is amended—

18 (1) in subsection (a)(1), by striking “2015” and
19 inserting “2017”; and

20 (2) in subsection (g), by inserting “and
21 \$40,000,000 for the period of fiscal years 2016 and
22 2017” after “2015”.

1 **SEC. 304. EXTENSION OF CERTAIN PROGRAMS AND DEM-**
2 **ONSTRATION PROJECTS.**

3 (a) CHILDHOOD OBESITY DEMONSTRATION
4 PROJECT.—Section 1139A(e)(8) of the Social Security
5 Act (42 U.S.C. 1320b–9a(e)(8)) is amended by inserting
6 “, and \$10,000,000 for the period of fiscal years 2016
7 and 2017” after “2014”.

8 (b) PEDIATRIC QUALITY MEASURES PROGRAM.—
9 Section 1139A(i) of the Social Security Act (42 U.S.C.
10 1320b–9a(i)) is amended in the first sentence by inserting
11 before the period at the end the following: “, and there
12 is appropriated for the period of fiscal years 2016 and
13 2017, \$20,000,000 for the purpose of carrying out this
14 section (other than subsections (e), (f), and (g))”.

15 **SEC. 305. REPORT OF INSPECTOR GENERAL OF HHS ON**
16 **USE OF EXPRESS LANE OPTION UNDER MED-**
17 **ICAID AND CHIP.**

18 Not later than 18 months after the date of the enact-
19 ment of this Act, the Inspector General of the Department
20 of Health and Human Services shall submit to the Com-
21 mittee on Energy and Commerce of the House of Rep-
22 resentatives and the Committee on Finance of the Senate
23 a report that—

24 (1) provides data on the number of individuals
25 enrolled in the Medicaid program under title XIX of
26 the Social Security Act (referred to in this section

as “Medicaid”) and the Children’s Health Insurance Program under title XXI of such Act (referred to in this section as “CHIP”) through the use of the Express Lane option under section 1902(e)(13) of the Social Security Act (42 U.S.C. 1396a(e)(13));

(2) assesses the extent to which individuals so enrolled meet the eligibility requirements under Medicaid or CHIP (as applicable); and

(3) provides data on Federal and State expenditures under Medicaid and CHIP for individuals so enrolled and disaggregates such data between expenditures made for individuals who meet the eligibility requirements under Medicaid or CHIP (as applicable) and expenditures made for individuals who do not meet such requirements.

TITLE IV—OFFSETS

Subtitle A—Medicare Beneficiary Reforms

SEC. 401. LIMITATION ON CERTAIN MEDIGAP POLICIES FOR NEWLY ELIGIBLE MEDICARE BENEFICIARIES.

Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

1 “(z) LIMITATION ON CERTAIN MEDIGAP POLICIES
2 FOR NEWLY ELIGIBLE MEDICARE BENEFICIARIES.—

3 “(1) IN GENERAL.—Notwithstanding any other
4 provision of this section, on or after January 1,
5 2020, a medicare supplemental policy that provides
6 coverage of the part B deductible, including any
7 such policy (or rider to such a policy) issued under
8 a waiver granted under subsection (p)(6), may not
9 be sold or issued to a newly eligible Medicare bene-
10 ficiary.

11 “(2) NEWLY ELIGIBLE MEDICARE BENEFICIARY
12 DEFINED.—In this subsection, the term ‘newly eligi-
13 ble Medicare beneficiary’ means an individual who is
14 neither of the following:

15 “(A) An individual who has attained age
16 65 before January 1, 2020.

17 “(B) An individual who was entitled to
18 benefits under part A pursuant to section
19 226(b) or 226A, or deemed to be eligible for
20 benefits under section 226(a), before January
21 1, 2020.

22 “(3) TREATMENT OF WAIVERED STATES.—In
23 the case of a State described in subsection (p)(6),
24 nothing in this section shall be construed as pre-
25 venting the State from modifying its alternative sim-

plification program under such subsection so as to eliminate the coverage of the part B deductible for any medical supplemental policy sold or issued under such program to a newly eligible Medicare beneficiary on or after January 1, 2020.

“(4) TREATMENT OF REFERENCES TO CERTAIN POLICIES.—In the case of a newly eligible Medicare beneficiary, except as the Secretary may otherwise provide, any reference in this section to a medicare supplemental policy which has a benefit package classified as ‘C’ or ‘F’ shall be deemed, as of January 1, 2020, to be a reference to a medicare supplemental policy which has a benefit package classified as ‘D’ or ‘G’, respectively.

“(5) ENFORCEMENT.—The penalties described in clause (ii) of subsection (d)(3)(A) shall apply with respect to a violation of paragraph (1) in the same manner as it applies to a violation of clause (i) of such subsection.”.

SEC. 402. INCOME-RELATED PREMIUM ADJUSTMENT FOR PARTS B AND D.

(a) IN GENERAL.—Section 1839(i)(3)(C)(i) of the Social Security Act (42 U.S.C. 1395r(i)(3)(C)(i)) is amended—

1 (1) by inserting after “IN GENERAL.—” the fol-
 2 lowing:

3 “(I) Subject to paragraphs (5)
 4 and (6), for years before 2018.”; and
 5 (2) by adding at the end the following:

6 “(II) Subject to paragraph (5),
 7 for years beginning with 2018:

“If the modified adjusted gross income is:	The applicable percentage is:
More than \$85,000 but not more than \$107,000	35 percent
More than \$107,000 but not more than \$133,500	50 percent
More than \$133,500 but not more than \$160,000	65 percent
More than \$160,000	80 percent.”.

8 (b) CONFORMING AMENDMENTS.—Section 1839(i) of
 9 the Social Security Act (42 U.S.C. 1395r(i)) is amended—

10 (1) in paragraph (2)(A), by inserting “(or, be-
 11 ginning with 2018, \$85,000)” after “\$80,000”;

12 (2) in paragraph (3)(A)(i), by inserting “appli-
 13 cable” before “table”;

14 (3) in paragraph (5)(A)—

15 (A) in the matter before clause (i), by in-
 16 serting “(other than 2018 and 2019)” after
 17 “2007”; and

18 (B) in clause (ii), by inserting “(or, in the
 19 case of a calendar year beginning with 2020,
 20 August 2018)” after “August 2006”; and

(4) in paragraph (6), in the matter before subparagraph (A), by striking “2019” and inserting “2017”.

Subtitle B—Other Offsets

SEC. 411. MEDICARE PAYMENT UPDATES FOR POST-ACUTE PROVIDERS.

(a) SNFs.—Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e))—

(1) in paragraph (5)(B)—

(A) in clause (i), by striking “clause (ii)” and inserting “clauses (ii) and (iii)”;

(B) in clause (ii), by inserting “subject to clause (iii),” after “each subsequent fiscal year,”; and

(C) by adding at the end the following new clause:

“(iii) SPECIAL RULE FOR FISCAL YEAR 2018.—For fiscal year 2018 (or other similar annual period specified in clause (i)), the skilled nursing facility market basket percentage, after application of clause (ii), is equal to 1 percent.”; and

(2) in paragraph (6)(A)(i), by striking “paragraph (5)(B)(ii)” and inserting “clauses (ii) and (iii) of paragraph (5)(B)”.

1 (b) IRFs.—Section 1886(j) of the Social Security Act
2 (42 U.S.C. 1395ww(j)) is amended—

3 (1) in paragraph (3)(C)—

4 (A) in clause (i), by striking “clause (ii)”
5 and inserting “clauses (ii) and (iii)”;

6 (B) in clause (ii), by striking “After” and
7 inserting “Subject to clause (iii), after”; and

8 (C) by adding at the end the following new
9 clause:

10 “(iii) SPECIAL RULE FOR FISCAL
11 YEAR 2018.—The increase factor to be ap-
12 plied under this subparagraph for fiscal
13 year 2018, after the application of clause
14 (ii), shall be 1 percent.”; and

15 (2) in paragraph (7)(A)(i), by striking “para-
16 graph (3)(D)” and inserting “subparagraphs (C)(iii)
17 and (D) of paragraph (3)”.

18 (c) HHAS.—Section 1895(b)(3)(B) of the Social Se-
19 curity Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

20 (1) in clause (iii), by adding at the end the fol-
21 lowing: “Notwithstanding the previous sentence, the
22 home health market basket percentage increase for
23 2018 shall be 1 percent.”; and

24 (2) in clause (vi)(I), by inserting “(except
25 2018)” after “each subsequent year”.

1 (d) HOSPICE.—Section 1814(i) of the Social Security
2 Act (42 U.S.C. 1395f(i)) is amended—

3 (1) in paragraph (1)(C)—

4 (A) in clause (ii)(VII), by striking “clause
5 (iv),,” and inserting “clauses (iv) and (vi),”;

6 (B) in clause (iii), by striking “clause
7 (iv),” and inserting “clauses (iv) and (vi),”;

8 (C) in clause (iv), by striking “After deter-
9 mining” and inserting “Subject to clause (vi),
10 after determining”; and

11 (D) by adding at the end the following new
12 clause:

13 “(vi) For fiscal year 2018, the market basket per-
14 centage increase under clause (ii)(VII) or (iii), as applica-
15 ble, after application of clause (iv), shall be 1 percent.”;
16 and

17 (2) in paragraph (5)(A)(i), by striking “para-
18 graph (1)(C)(iv)” and inserting “clauses (iv) and
19 (vi) of paragraph (1)(C)”.

20 (e) LTCHs.—Section 1886(m)(3) of the Social Secu-
21 rity Act (42 U.S.C. 1395ww(m)(3)) is amended—

22 (1) in subparagraph (A), in the matter pre-
23 ceding clause (i), by striking “In implementing” and
24 inserting “Subject to subparagraph (C), in imple-
25 menting”; and

1 (2) by adding at the end the following new sub-
2 paragraph:

3 “(C) **ADDITIONAL SPECIAL RULE.**—For
4 fiscal year 2018, the annual update under sub-
5 paragraph (A) for the fiscal year, after applica-
6 tion of clauses (i) and (ii) of subparagraph (A),
7 shall be 1 percent.”.

8 **SEC. 412. DELAY OF REDUCTION TO MEDICAID DSH ALLOT-**
9 **MENTS.**

10 Section 1923(f) of the Social Security Act (42 U.S.C.
11 1396r-4(f)) is amended—

12 (1) in paragraph (7)(A)—

13 (A) in clause (i), by striking “2017
14 through 2024” and inserting “2018 through
15 2025”;

16 (B) by striking clause (ii) and inserting the
17 following new clause:

18 “(ii) **AGGREGATE REDUCTIONS.**—The
19 aggregate reductions in DSH allotments
20 for all States under clause (i)(I) shall be
21 equal to—

22 “(I) \$2,000,000,000 for fiscal
23 year 2018;

24 “(II) \$3,000,000,000 for fiscal
25 year 2019;

1 “(III) \$4,000,000,000 for fiscal
2 year 2020;

3 “(IV) \$5,000,000,000 for fiscal
4 year 2021;

5 “(V) \$6,000,000,000 for fiscal
6 year 2022;

7 “(VI) \$7,000,000,000 for fiscal
8 year 2023;

9 “(VII) \$8,000,000,000 for fiscal
10 year 2024; and

11 “(VIII) \$8,000,000,000 for fiscal
12 year 2025.”; and

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

15 “(v) DISTRIBUTION OF AGGREGATE
16 REDUCTIONS.—The Secretary shall dis-
17 tribute the aggregate reductions under
18 clause (ii) among States in accordance
19 with subparagraph (B).”; and

20 (2) in paragraph (8), by striking “2024” and
21 inserting “2025”.

22 **SEC. 413. LEVY ON DELINQUENT PROVIDERS.**

23 (a) IN GENERAL.—Paragraph (3) of section 6331(h)
24 of the Internal Revenue Code of 1986 is amended by strik-
25 ing “30 percent” and inserting “100 percent”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 this section shall apply to payments made after 180 days
3 after the date of the enactment of this Act.

4 **SEC. 414. ADJUSTMENTS TO INPATIENT HOSPITAL PAY-**
5 **MENT RATES.**

6 Section 7(b) of the TMA, Abstinence Education, and
7 QI Programs Extension Act of 2007 (Public Law 110–
8 90), as amended by the American Taxpayer Relief Act of
9 2012 (Public Law 112–240), is amended—

10 (1) in paragraph (1)—

11 (A) in the matter preceding subparagraph
12 (A), by striking “, 2009, or 2010” and insert-
13 ing “or 2009”; and

14 (B) in subparagraph (B)—

15 (i) in clause (i), by striking “and” at
16 the end;

17 (ii) in clause (ii), by striking the pe-
18 riod at the end and inserting “; and”; and

19 (iii) by adding at the end the fol-
20 lowing new clause:

21 “(iii) make an additional adjustment to the
22 standardized amounts under such section
23 1886(d) of an increase of 0.5 percentage points
24 for discharges occurring during each of fiscal
25 years 2018 through 2023 and not make the ad-

1 justment (estimated to be an increase of 3.2
2 percent) that would otherwise apply for dis-
3 charges occurring during fiscal year 2018 by
4 reason of the completion of the adjustments re-
5 quired under clause (ii).”;

6 (2) in paragraph (3)—

7 (A) by striking “shall be construed” and
8 all that follows through “providing authority”
9 and inserting “shall be construed as providing
10 authority”; and

11 (B) by inserting “and each succeeding fis-
12 cal year through fiscal year 2023” after
13 “2017”;

14 (3) by redesignating paragraphs (3) and (4) as
15 paragraphs (4) and (5), respectively; and

16 (4) by inserting after paragraph (2) the fol-
17 lowing new paragraph:

18 “(3) PROHIBITION.—The Secretary shall not
19 make an additional prospective adjustment (esti-
20 mated to be a decrease of 0.55 percent) to the
21 standardized amounts under such section 1886(d) to
22 offset the amount of the increase in aggregate pay-
23 ments related to documentation and coding changes
24 for discharges occurring during fiscal year 2010.”.

1 **TITLE V—MISCELLANEOUS**
2 **Subtitle A—Protecting the**
3 **Integrity of Medicare**

4 **SEC. 501. PROHIBITION OF INCLUSION OF SOCIAL SECU-**
5 **RITY ACCOUNT NUMBERS ON MEDICARE**
6 **CARDS.**

7 (a) IN GENERAL.—Section 205(c)(2)(C) of the Social
8 Security Act (42 U.S.C. 405(c)(2)(C)) is amended—

9 (1) by moving clause (x), as added by section
10 1414(a)(2) of the Patient Protection and Affordable
11 Care Act, 6 ems to the left;

12 (2) by redesignating clause (x), as added by
13 section 2(a)(1) of the Social Security Number Pro-
14 tection Act of 2010, and clause (xi) as clauses (xi)
15 and (xii), respectively; and

16 (3) by adding at the end the following new
17 clause:

18 “(xiii) The Secretary of Health and Human Services,
19 in consultation with the Commissioner of Social Security,
20 shall establish cost-effective procedures to ensure that a
21 Social Security account number (or derivative thereof) is
22 not displayed, coded, or embedded on the Medicare card
23 issued to an individual who is entitled to benefits under
24 part A of title XVIII or enrolled under part B of title
25 XVIII and that any other identifier displayed on such card

1 is not identifiable as a Social Security account number (or
2 derivative thereof).”.

3 (b) IMPLEMENTATION.—In implementing clause (xiii)
4 of section 205(c)(2)(C) of the Social Security Act (42
5 U.S.C. 405(c)(2)(C)), as added by subsection (a)(3), the
6 Secretary of Health and Human Services shall do the fol-
7 lowing:

8 (1) IN GENERAL.—Establish a cost-effective
9 process that involves the least amount of disruption
10 to, as well as necessary assistance for, Medicare
11 beneficiaries and health care providers, such as a
12 process that provides such beneficiaries with access
13 to assistance through a toll-free telephone number
14 and provides outreach to providers.

15 (2) CONSIDERATION OF MEDICARE BENE-
16 FICIARY IDENTIFIED.—Consider implementing a
17 process, similar to the process involving Railroad Re-
18 tirement Board beneficiaries, under which a Medi-
19 care beneficiary identifier which is not a Social Secu-
20 rity account number (or derivative thereof) is used
21 external to the Department of Health and Human
22 Services and is convertible over to a Social Security
23 account number (or derivative thereof) for use inter-
24 nal to such Department and the Social Security Ad-
25 ministration.

1 (c) FUNDING FOR IMPLEMENTATION.—For purposes
2 of implementing the provisions of and the amendments
3 made by this section, the Secretary of Health and Human
4 Services shall provide for the following transfers from the
5 Federal Hospital Insurance Trust Fund under section
6 1817 of the Social Security Act (42 U.S.C. 1395i) and
7 from the Federal Supplementary Medical Insurance Trust
8 Fund established under section 1841 of such Act (42
9 U.S.C. 1395t), in such proportions as the Secretary deter-
10 mines appropriate:

11 (1) To the Centers for Medicare & Medicaid
12 Program Management Account, transfers of the fol-
13 lowing amounts:

14 (A) For fiscal year 2015, \$65,000,000, to
15 be made available through fiscal year 2018.

16 (B) For each of fiscal years 2016 and
17 2017, \$53,000,000, to be made available
18 through fiscal year 2018.

19 (C) For fiscal year 2018, \$48,000,000, to
20 be made available until expended.

21 (2) To the Social Security Administration Limi-
22 tation on Administration Account, transfers of the
23 following amounts:

24 (A) For fiscal year 2015, \$27,000,000, to
25 be made available through fiscal year 2018.

1 (B) For each of fiscal years 2016 and
2 2017, \$22,000,000, to be made available
3 through fiscal year 2018.

4 (C) For fiscal year 2018, \$27,000,000, to
5 be made available until expended.

6 (3) To the Railroad Retirement Board Limita-
7 tion on Administration Account, the following
8 amount:

9 (A) For fiscal year 2015, \$3,000,000, to
10 be made available until expended.

11 (d) EFFECTIVE DATE.—

12 (1) IN GENERAL.—Clause (xiii) of section
13 205(c)(2)(C) of the Social Security Act (42 U.S.C.
14 405(c)(2)(C)), as added by subsection (a)(3), shall
15 apply with respect to Medicare cards issued on and
16 after an effective date specified by the Secretary of
17 Health and Human Services, but in no case shall
18 such effective date be later than the date that is four
19 years after the date of the enactment of this Act.

20 (2) REISSUANCE.—The Secretary shall provide
21 for the reissuance of Medicare cards that comply
22 with the requirements of such clause not later than
23 four years after the effective date specified by the
24 Secretary under paragraph (1).

1 **SEC. 502. PREVENTING WRONGFUL MEDICARE PAYMENTS**
2 **FOR ITEMS AND SERVICES FURNISHED TO IN-**
3 **CARCERATED INDIVIDUALS, INDIVIDUALS**
4 **NOT LAWFULLY PRESENT, AND DECEASED IN-**
5 **DIVIDUALS.**

6 (a) REQUIREMENT FOR THE SECRETARY TO ESTAB-
7 LISH POLICIES AND CLAIMS EDITS RELATING TO INCAR-
8 CERATED INDIVIDUALS, INDIVIDUALS NOT LAWFULLY
9 PRESENT, AND DECEASED INDIVIDUALS.—Section 1874
10 of the Social Security Act (42 U.S.C. 1395kk) is amended
11 by adding at the end the following new subsection:

12 “(f) REQUIREMENT FOR THE SECRETARY TO ESTAB-
13 LISH POLICIES AND CLAIMS EDITS RELATING TO INCAR-
14 CERATED INDIVIDUALS, INDIVIDUALS NOT LAWFULLY
15 PRESENT, AND DECEASED INDIVIDUALS.—The Secretary
16 shall establish and maintain procedures, including proce-
17 dures for using claims processing edits, updating eligibility
18 information to improve provider accessibility, and con-
19 ducting recoupment activities such as through recovery
20 audit contractors, in order to ensure that payment is not
21 made under this title for items and services furnished to
22 an individual who is one of the following:

23 “(1) An individual who is incarcerated.

24 “(2) An individual who is not lawfully present
25 in the United States and who is not eligible for cov-
26 erage under this title.

1 “(3) A deceased individual.”.

2 (b) REPORT.—Not later than 18 months after the
3 date of the enactment of this section, and periodically
4 thereafter as determined necessary by the Office of Inspec-
5 tor General of the Department of Health and Human
6 Services, such Office shall submit to Congress a report
7 on the activities described in subsection (f) of section 1874
8 of the Social Security Act (42 U.S.C. 1395kk), as added
9 by subparagraph (a), that have been conducted since such
10 date of enactment.

11 **SEC. 503. CONSIDERATION OF MEASURES REGARDING**
12 **MEDICARE BENEFICIARY SMART CARDS.**

13 To the extent the Secretary of Health and Human
14 Services determines that it is cost effective and techno-
15 logically viable to use electronic Medicare beneficiary and
16 provider cards (such as cards that use smart card tech-
17 nology, including an embedded and secure integrated cir-
18 cuit chip), as presented in the Government Accountability
19 Office report required by the conference report accom-
20 panying the Consolidated Appropriations Act, 2014 (Pub-
21 lic Law 113–76), the Secretary shall consider such meas-
22 ures as determined appropriate by the Secretary to imple-
23 ment such use of such cards for beneficiary and provider
24 use under title XVIII of the Social Security Act (42
25 U.S.C. 1395 et seq.). In the case that the Secretary con-

1 siders measures under the preceding sentence, the Sec-
 2 retary shall submit to the Committees on Ways and Means
 3 and Energy and Commerce of the House of Representa-
 4 tives, and to the Committee on Finance of the Senate, a
 5 report outlining the considerations undertaken by the Sec-
 6 retary under such sentence.

7 **SEC. 504. MODIFYING MEDICARE DURABLE MEDICAL**
 8 **EQUIPMENT FACE-TO-FACE ENCOUNTER**
 9 **DOCUMENTATION REQUIREMENT.**

10 (a) IN GENERAL.—Section 1834(a)(11)(B)(ii) of the
 11 Social Security Act (42 U.S.C. 1395m(a)(11)(B)(ii)) is
 12 amended—

13 (1) by striking “the physician documenting
 14 that”; and

15 (2) by striking “has had a face-to-face encoun-
 16 ter” and inserting “documenting such physician,
 17 physician assistant, practitioner, or specialist has
 18 had a face-to-face encounter”.

19 (b) IMPLEMENTATION.—Notwithstanding any other
 20 provision of law, the Secretary of Health and Human
 21 Services may implement the amendments made by sub-
 22 section (a) by program instruction or otherwise.

1 **SEC. 505. REDUCING IMPROPER MEDICARE PAYMENTS.**

2 (a) MEDICARE ADMINISTRATIVE CONTRACTOR IM-
3 PROPER PAYMENT OUTREACH AND EDUCATION PRO-
4 GRAM.—

5 (1) IN GENERAL.—Section 1874A of the Social
6 Security Act (42 U.S.C. 1395kk–1) is amended—

7 (A) in subsection (a)(4)—

8 (i) by redesignating subparagraph (G)
9 as subparagraph (H); and

10 (ii) by inserting after subparagraph
11 (F) the following new subparagraph:

12 “(G) IMPROPER PAYMENT OUTREACH AND
13 EDUCATION PROGRAM.—Having in place an im-
14 proper payment outreach and education pro-
15 gram described in subsection (h).”; and

16 (B) by adding at the end the following new
17 subsection:

18 “(h) IMPROPER PAYMENT OUTREACH AND EDU-
19 CATION PROGRAM.—

20 “(1) IN GENERAL.—In order to reduce im-
21 proper payments under this title, each medicare ad-
22 ministrative contractor shall establish and have in
23 place an improper payment outreach and education
24 program under which the contractor, through out-
25 reach, education, training, and technical assistance
26 or other activities, shall provide providers of services

1 and suppliers located in the region covered by the
2 contract under this section with the information de-
3 scribed in paragraph (2). The activities described in
4 the preceding sentence shall be conducted on a reg-
5 ular basis.

6 “(2) INFORMATION TO BE PROVIDED THROUGH
7 ACTIVITIES.—The information to be provided under
8 such payment outreach and education program shall
9 include information the Secretary determines to be
10 appropriate which may include the following infor-
11 mation:

12 “(A) A list of the providers’ or suppliers’
13 most frequent and expensive payment errors
14 over the last quarter.

15 “(B) Specific instructions regarding how to
16 correct or avoid such errors in the future.

17 “(C) A notice of new topics that have been
18 approved by the Secretary for audits conducted
19 by recovery audit contractors under section
20 1893(h).

21 “(D) Specific instructions to prevent fu-
22 ture issues related to such new audits.

23 “(E) Other information determined appro-
24 priate by the Secretary.

1 “(3) PRIORITY.—A medicare administrative
2 contractor shall give priority to activities under such
3 program that will reduce improper payments that
4 are one or more of the following:

5 “(A) Are for items and services that have
6 the highest rate of improper payment.

7 “(B) Are for items and service that have
8 the greatest total dollar amount of improper
9 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.

14 “(E) Are due to other types of errors that
15 the Secretary determines could be prevented
16 through activities under the program.

17 “(4) 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 the types of im-
24 proper payments identified by recovery audit
25 contractors under section 1893(h) with respect

1 to providers of services and suppliers located in
2 the region covered by the contract under this
3 section. Such information shall be provided on
4 a time frame the Secretary determines appro-
5 priate which may be on a quarterly basis.

6 “(B) INFORMATION.—The information de-
7 scribed in subparagraph (A) shall include infor-
8 mation such as the following:

9 “(i) Providers of services and sup-
10 pliers that have the highest rate of im-
11 proper payments.

12 “(ii) Providers of services and sup-
13 pliers that have the greatest total dollar
14 amounts of improper payments.

15 “(iii) Items and services furnished in
16 the region that have the highest rates of
17 improper payments.

18 “(iv) Items and services furnished in
19 the region that are responsible for the
20 greatest total dollar amount of improper
21 payments.

22 “(v) Other information the Secretary
23 determines would assist the contractor in
24 carrying out the program.

1 “(5) COMMUNICATIONS.—Communications with
 2 providers of services and suppliers under an im-
 3 proper payment outreach and education program are
 4 subject to the standards and requirements of sub-
 5 section (g).”.

6 (b) USE OF CERTAIN FUNDS RECOVERED BY
 7 RACs.—Section 1893(h) of the Social Security Act (42
 8 U.S.C. 1395ddd(h)) is amended—

9 (1) in paragraph (2), by inserting “or para-
 10 graph (10)” after “paragraph (1)(C)”; and

11 (2) by adding at the end the following new
 12 paragraph:

13 “(10) USE OF CERTAIN RECOVERED FUNDS.—

14 “(A) IN GENERAL.—After application of
 15 paragraph (1)(C), the Secretary shall retain a
 16 portion of the amounts recovered by recovery
 17 audit contractors for each year under this sec-
 18 tion which shall be available to the program
 19 management account of the Centers for Medi-
 20 care & Medicaid Services for purposes of, sub-
 21 ject to subparagraph (B), carrying out sections
 22 1833(z), 1834(l)(16), and 1874A(a)(4)(G), car-
 23 rying out section 514(b) of the Medicare Access
 24 and CHIP Reauthorization Act of 2015, and
 25 implementing strategies (such as claims proc-

essing edits) to help reduce the error rate of payments under this title. The amounts retained under the preceding sentence shall not exceed an amount equal to 15 percent of the amounts recovered under this subsection, and shall remain available until expended.

“(B) LIMITATION.—Except for uses that support claims processing (including edits) or system functionality for detecting fraud, amounts retained under subparagraph (A) may not be used for technological-related infrastructure, capital investments, or information systems.

“(C) NO REDUCTION IN PAYMENTS TO RECOVERY AUDIT CONTRACTORS.—Nothing in subparagraph (A) shall reduce amounts available for payments to recovery audit contractors under this subsection.”.

SEC. 506. IMPROVING SENIOR MEDICARE PATROL AND FRAUD REPORTING REWARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall develop a plan to revise the incentive program under section 203(b) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1395b–

1 5(b)) to encourage greater participation by individuals to
2 report fraud and abuse in the Medicare program. Such
3 plan shall include recommendations for—

4 (1) ways to enhance rewards for individuals re-
5 porting under the incentive program, including re-
6 wards based on information that leads to an admin-
7 istrative action; and

8 (2) extending the incentive program to the
9 Medicaid program.

10 (b) PUBLIC AWARENESS AND EDUCATION CAM-
11 PAIGN.—The plan developed under subsection (a) shall
12 also include recommendations for the use of the Senior
13 Medicare Patrols authorized under section 411 of the
14 Older Americans Act of 1965 (42 U.S.C. 3032) to conduct
15 a public awareness and education campaign to encourage
16 participation in the revised incentive program under sub-
17 section (a).

18 (c) SUBMISSION OF PLAN.—Not later than 180 days
19 after the date of enactment of this Act, the Secretary shall
20 submit to Congress the plan developed under subsection
21 (a).

1 **SEC. 507. REQUIRING VALID PRESCRIBER NATIONAL PRO-**
2 **VIDER IDENTIFIERS ON PHARMACY CLAIMS.**

3 Section 1860D–4(c) of the Social Security Act (42
4 U.S.C. 1395w–104(c)) is amended by adding at the end
5 the following new paragraph:

6 “(4) REQUIRING VALID PRESCRIBER NATIONAL
7 PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.—

8 “(A) IN GENERAL.—For plan year 2016
9 and subsequent plan years, the Secretary shall
10 require a claim for a covered part D drug for
11 a part D eligible individual enrolled in a pre-
12 scription drug plan under this part or an MA-
13 PD plan under part C to include a prescriber
14 National Provider Identifier that is determined
15 to be valid under the procedures established
16 under subparagraph (B)(i).

17 “(B) PROCEDURES.—

18 “(i) VALIDITY OF PRESCRIBER NA-
19 TIONAL PROVIDER IDENTIFIERS.—The
20 Secretary, in consultation with appropriate
21 stakeholders, shall establish procedures for
22 determining the validity of prescriber Na-
23 tional Provider Identifiers under subpara-
24 graph (A).

25 “(ii) INFORMING BENEFICIARIES OF
26 REASON FOR DENIAL.—The Secretary shall

1 establish procedures to ensure that, in the
2 case that a claim for a covered part D
3 drug of an individual described in subpara-
4 graph (A) is denied because the claim does
5 not meet the requirements of this para-
6 graph, the individual is properly informed
7 at the point of service of the reason for the
8 denial.

9 “(C) REPORT.—Not later than January 1,
10 2018, the Inspector General of the Department
11 of Health and Human Services shall submit to
12 Congress a report on the effectiveness of the
13 procedures established under subparagraph
14 (B)(i).”.

15 **SEC. 508. OPTION TO RECEIVE MEDICARE SUMMARY NO-**
16 **TICE ELECTRONICALLY.**

17 (a) IN GENERAL.—Section 1806 of the Social Secu-
18 rity Act (42 U.S.C. 1395b–7) is amended by adding at
19 the end the following new subsection:

20 “(c) FORMAT OF STATEMENTS FROM SECRETARY.—

21 “(1) ELECTRONIC OPTION BEGINNING IN
22 2016.—Subject to paragraph (2), for statements de-
23 scribed in subsection (a) that are furnished for a pe-
24 riod in 2016 or a subsequent year, in the case that
25 an individual described in subsection (a) elects, in

1 accordance with such form, manner, and time speci-
2 fied by the Secretary, to receive such statement in
3 an electronic format, such statement shall be fur-
4 nished to such individual for each period subsequent
5 to such election in such a format and shall not be
6 mailed to the individual.

7 “(2) LIMITATION ON REVOCATION OPTION.—

8 “(A) IN GENERAL.—Subject to subpara-
9 graph (B), the Secretary may determine a max-
10 imum number of elections described in para-
11 graph (1) by an individual that may be revoked
12 by the individual.

13 “(B) MINIMUM OF ONE REVOCATION OP-
14 TION.—In no case may the Secretary determine
15 a maximum number under subparagraph (A)
16 that is less than one.

17 “(3) NOTIFICATION.—The Secretary shall en-
18 sure that, in the most cost effective manner and be-
19 ginning January 1, 2017, a clear notification of the
20 option to elect to receive statements described in
21 subsection (a) in an electronic format is made avail-
22 able, such as through the notices distributed under
23 section 1804, to individuals described in subsection
24 (a).”.

1 (b) ENCOURAGED EXPANSION OF ELECTRONIC
 2 STATEMENTS.—To the extent to which the Secretary of
 3 Health and Human Services determines appropriate, the
 4 Secretary shall—

5 (1) apply an option similar to the option de-
 6 scribed in subsection (c)(1) of section 1806 of the
 7 Social Security Act (42 U.S.C. 1395b–7) (relating to
 8 the provision of the Medicare Summary Notice in an
 9 electronic format), as added by subsection (a), to
 10 other statements and notifications under title XVIII
 11 of such Act (42 U.S.C. 1395 et seq.); and

12 (2) provide such Medicare Summary Notice and
 13 any such other statements and notifications on a
 14 more frequent basis than is otherwise required under
 15 such title.

16 **SEC. 509. RENEWAL OF MAC CONTRACTS.**

17 (a) IN GENERAL.—Section 1874A(b)(1)(B) of the
 18 Social Security Act (42 U.S.C. 1395kk–1(b)(1)(B)) is
 19 amended by striking “5 years” and inserting “10 years”.

20 (b) APPLICATION.—The amendments made by sub-
 21 section (a) shall apply to contracts entered into on or
 22 after, and to contracts in effect as of, the date of the en-
 23 actment of this Act.

24 (c) CONTRACTOR PERFORMANCE TRANSPARENCY.—
 25 Section 1874A(b)(3)(A) of the Social Security Act (42

1 U.S.C. 1395kk–1(b)(3)(A)) is amended by adding at the
 2 end the following new clause:

3 “(iv) CONTRACTOR PERFORMANCE
 4 TRANSPARENCY.—To the extent possible
 5 without compromising the process for en-
 6 tering into and renewing contracts with
 7 medicare administrative contractors under
 8 this section, the Secretary shall make
 9 available to the public the performance of
 10 each medicare administrative contractor
 11 with respect to such performance require-
 12 ments and measurement standards.”.

13 **SEC. 510. STUDY ON PATHWAY FOR INCENTIVES TO STATES**
 14 **FOR STATE PARTICIPATION IN MEDICAID**
 15 **DATA MATCH PROGRAM.**

16 Section 1893(g) of the Social Security Act (42 U.S.C.
 17 1395ddd(g)) is amended by adding at the end the fol-
 18 lowing new paragraph:

19 “(3) INCENTIVES FOR STATES.—The Secretary
 20 shall study and, as appropriate, may specify incen-
 21 tives for States to work with the Secretary for the
 22 purposes described in paragraph (1)(A)(ii). The ap-
 23 plication of the previous sentence may include use of
 24 the waiver authority described in paragraph (2).”.

1 **SEC. 511. GUIDANCE ON APPLICATION OF COMMON RULE**
2 **TO CLINICAL DATA REGISTRIES.**

3 Not later than one year after the date of the enact-
4 ment of this section, the Secretary of Health and Human
5 Services shall issue a clarification or modification with re-
6 spect to the application of subpart A of part 46 of title
7 45, Code of Federal Regulations, governing the protection
8 of human subjects in research (and commonly known as
9 the “Common Rule”), to activities, including quality im-
10 provement activities, involving clinical data registries, in-
11 cluding entities that are qualified clinical data registries
12 pursuant to section 1848(m)(3)(E) of the Social Security
13 Act (42 U.S.C. 1395w–4(m)(3)(E)).

14 **SEC. 512. ELIMINATING CERTAIN CIVIL MONEY PENALTIES;**
15 **GAINSHARING STUDY AND REPORT.**

16 (a) **ELIMINATING CIVIL MONEY PENALTIES FOR IN-**
17 **DUCEMENTS TO PHYSICIANS TO LIMIT SERVICES THAT**
18 **ARE NOT MEDICALLY NECESSARY.—**

19 (1) **IN GENERAL.**—Section 1128A(b)(1) of the
20 Social Security Act (42 U.S.C. 1320a–7a(b)(1)) is
21 amended by inserting “medically necessary” after
22 “reduce or limit”.

23 (2) **EFFECTIVE DATE.**—The amendment made
24 by paragraph (1) shall apply to payments made on
25 or after the date of the enactment of this Act.

1 (b) GAINSHARING STUDY AND REPORT.—Not later
2 than 12 months after the date of the enactment of this
3 Act, the Secretary of Health and Human Services, in con-
4 sultation with the Inspector General of the Department
5 of Health and Human Services, shall submit to Congress
6 a report with options for amending existing fraud and
7 abuse laws in, and regulations related to, titles XI and
8 XVIII of the Social Security Act (42 U.S.C. 301 et seq.),
9 through exceptions, safe harbors, or other narrowly tar-
10 geted provisions, to permit gainsharing arrangements that
11 otherwise would be subject to the civil money penalties de-
12 scribed in paragraphs (1) and (2) of section 1128A(b) of
13 such Act (42 U.S.C. 1320a–7a(b)), or similar arrange-
14 ments between physicians and hospitals, and that improve
15 care while reducing waste and increasing efficiency. The
16 report shall—

17 (1) consider whether such provisions should
18 apply to ownership interests, compensation arrange-
19 ments, or other relationships;

20 (2) describe how the recommendations address
21 accountability, transparency, and quality, including
22 how best to limit inducements to stint on care, dis-
23 charge patients prematurely, or otherwise reduce or
24 limit medically necessary care; and

1 (3) consider whether a portion of any savings
2 generated by such arrangements (as compared to an
3 historical benchmark or other metric specified by the
4 Secretary to determine the impact of delivery and
5 payment system changes under such title XVIII on
6 expenditures made under such title) should accrue to
7 the Medicare program under title XVIII of the So-
8 cial Security Act.

9 **SEC. 513. MODIFICATION OF MEDICARE HOME HEALTH**
10 **SURETY BOND CONDITION OF PARTICIPA-**
11 **TION REQUIREMENT.**

12 Section 1861(o)(7) of the Social Security Act (42
13 U.S.C. 1395x(o)(7)) is amended to read as follows:

14 “(7) provides the Secretary with a surety
15 bond—

16 “(A) in a form specified by the Secretary
17 and in an amount that is not less than the min-
18 imum of \$50,000; and

19 “(B) that the Secretary determines is com-
20 mensurate with the volume of payments to the
21 home health agency; and”.

1 **SEC. 514. OVERSIGHT OF MEDICARE COVERAGE OF MAN-**
2 **UAL MANIPULATION OF THE SPINE TO COR-**
3 **RECT SUBLUXATION.**

4 (a) IN GENERAL.—Section 1833 of the Social Secu-
5 rity Act (42 U.S.C. 1395l) is amended by adding at the
6 end the following new subsection:

7 “(z) MEDICAL REVIEW OF SPINAL SUBLUXATION
8 SERVICES.—

9 “(1) IN GENERAL.—The Secretary shall imple-
10 ment a process for the medical review (as described
11 in paragraph (2)) of treatment by a chiropractor de-
12 scribed in section 1861(r)(5) by means of manual
13 manipulation of the spine to correct a subluxation
14 (as described in such section) of an individual who
15 is enrolled under this part and apply such process to
16 such services furnished on or after January 1, 2017,
17 focusing on services such as—

18 “(A) services furnished by a such a chiro-
19 practor whose pattern of billing is aberrant
20 compared to peers; and

21 “(B) services furnished by such a chiro-
22 practor who, in a prior period, has a services
23 denial percentage in the 85th percentile or
24 greater, taking into consideration the extent
25 that service denials are overturned on appeal.

26 “(2) MEDICAL REVIEW.—

1 “(A) PRIOR AUTHORIZATION MEDICAL RE-
2 VIEW.—

3 “(i) IN GENERAL.—Subject to clause
4 (ii), the Secretary shall use prior author-
5 ization medical review for services de-
6 scribed in paragraph (1) that are furnished
7 to an individual by a chiropractor de-
8 scribed in section 1861(r)(5) that are part
9 of an episode of treatment that includes
10 more than 12 services. For purposes of the
11 preceding sentence, an episode of treat-
12 ment shall be determined by the underlying
13 cause that justifies the need for services,
14 such as a diagnosis code.

15 “(ii) ENDING APPLICATION OF PRIOR
16 AUTHORIZATION MEDICAL REVIEW.—The
17 Secretary shall end the application of prior
18 authorization medical review under clause
19 (i) to services described in paragraph (1)
20 by such a chiropractor if the Secretary de-
21 termines that the chiropractor has a low
22 denial rate under such prior authorization
23 medical review. The Secretary may subse-
24 quently reapply prior authorization medical
25 review to such chiropractor if the Secretary

1 determines it to be appropriate and the
2 chiropractor has, in the time period subse-
3 quent to the determination by the Sec-
4 retary of a low denial rate with respect to
5 the chiropractor, furnished such services
6 described in paragraph (1).

7 “(iii) EARLY REQUEST FOR PRIOR AU-
8 THORIZATION REVIEW PERMITTED.—Noth-
9 ing in this subsection shall be construed to
10 prevent such a chiropractor from request-
11 ing prior authorization for services de-
12 scribed in paragraph (1) that are to be
13 furnished to an individual before the chiro-
14 practor furnishes the twelfth such service
15 to such individual for an episode of treat-
16 ment.

17 “(B) TYPE OF REVIEW.—The Secretary
18 may use pre-payment review or post-payment
19 review of services described in section
20 1861(r)(5) that are not subject to prior author-
21 ization medical review under subparagraph (A).

22 “(C) RELATIONSHIP TO LAW ENFORCE-
23 MENT ACTIVITIES.—The Secretary may deter-
24 mine that medical review under this subsection

1 does not apply in the case where potential fraud
2 may be involved.

3 “(3) NO PAYMENT WITHOUT PRIOR AUTHORIZA-
4 TION.—With respect to a service described in para-
5 graph (1) for which prior authorization medical re-
6 view under this subsection applies, the following
7 shall apply:

8 “(A) PRIOR AUTHORIZATION DETERMINA-
9 TION.—The Secretary shall make a determina-
10 tion, prior to the service being furnished, of
11 whether the service would or would not meet
12 the applicable requirements of section
13 1862(a)(1)(A).

14 “(B) DENIAL OF PAYMENT.—Subject to
15 paragraph (5), no payment may be made under
16 this part for the service unless the Secretary
17 determines pursuant to subparagraph (A) that
18 the service would meet the applicable require-
19 ments of such section 1862(a)(1)(A).

20 “(4) SUBMISSION OF INFORMATION.—A chiro-
21 practor described in section 1861(r)(5) may submit
22 the information necessary for medical review by fax,
23 by mail, or by electronic means. The Secretary shall
24 make available the electronic means described in the
25 preceding sentence as soon as practicable.

1 “(5) TIMELINESS.—If the Secretary does not
2 make a prior authorization determination under
3 paragraph (3)(A) within 14 business days of the
4 date of the receipt of medical documentation needed
5 to make such determination, paragraph (3)(B) shall
6 not apply.

7 “(6) APPLICATION OF LIMITATION ON BENE-
8 FICIARY LIABILITY.—Where payment may not be
9 made as a result of the application of paragraph
10 (2)(B), section 1879 shall apply in the same manner
11 as such section applies to a denial that is made by
12 reason of section 1862(a)(1).

13 “(7) REVIEW BY CONTRACTORS.—The medical
14 review described in paragraph (2) may be conducted
15 by medicare administrative contractors pursuant to
16 section 1874A(a)(4)(G) or by any other contractor
17 determined appropriate by the Secretary that is not
18 a recovery audit contractor.

19 “(8) MULTIPLE SERVICES.—The Secretary
20 shall, where practicable, apply the medical review
21 under this subsection in a manner so as to allow an
22 individual described in paragraph (1) to obtain, at a
23 single time rather than on a service-by-service basis,
24 an authorization in accordance with paragraph
25 (3)(A) for multiple services.

1 “(9) CONSTRUCTION.—With respect to a serv-
 2 ice described in paragraph (1) that has been af-
 3 firmed by medical review under this subsection,
 4 nothing in this subsection shall be construed to pre-
 5 clude the subsequent denial of a claim for such serv-
 6 ice that does not meet other applicable requirements
 7 under this Act.

8 “(10) IMPLEMENTATION.—

9 “(A) AUTHORITY.—The Secretary may im-
 10 plement the provisions of this subsection by in-
 11 terim final rule with comment period.

12 “(B) ADMINISTRATION.—Chapter 35 of
 13 title 44, United States Code, shall not apply to
 14 medical review under this subsection.”.

15 (b) IMPROVING DOCUMENTATION OF SERVICES.—

16 (1) IN GENERAL.—The Secretary of Health and
 17 Human Services shall, in consultation with stake-
 18 holders (including the American Chiropractic Asso-
 19 ciation) and representatives of medicare administra-
 20 tive contractors (as defined in section
 21 1874A(a)(3)(A) of the Social Security Act (42
 22 U.S.C. 1395kk–1(a)(3)(A))), develop educational
 23 and training programs to improve the ability of
 24 chiropractors to provide documentation to the Sec-
 25 retary of services described in section 1861(r)(5) in

1 a manner that demonstrates that such services are,
2 in accordance with section 1862(a)(1) of such Act
3 (42 U.S.C. 1395y(a)(1)), reasonable and necessary
4 for the diagnosis or treatment of illness or injury or
5 to improve the functioning of a malformed body
6 member.

7 (2) TIMING.—The Secretary shall make the
8 educational and training programs described in
9 paragraph (1) publicly available not later than Janu-
10 ary 1, 2016.

11 (3) FUNDING.—The Secretary shall use funds
12 made available under paragraph (10) of section
13 1893(h) of the Social Security Act (42 U.S.C.
14 1395ddd(h)), as added by section 505, to carry out
15 this subsection.

16 (c) GAO STUDY AND REPORT.—

17 (1) STUDY.—The Comptroller General of the
18 United States shall conduct a study on the effective-
19 ness of the process for medical review of services
20 furnished as part of a treatment by means of man-
21 ual manipulation of the spine to correct a sub-
22 luxation implemented under subsection (z) of section
23 1833 of the Social Security Act (42 U.S.C. 1395l),
24 as added by subsection (a). Such study shall include
25 an analysis of—

1 (A) aggregate data on—

2 (i) the number of individuals, chiro-
3 practors, and claims for services subject to
4 such review; and

5 (ii) the number of reviews conducted
6 under such section; and

7 (B) the outcomes of such reviews.

8 (2) REPORT.—Not later than four years after
9 the date of enactment of this Act, the Comptroller
10 General shall submit to Congress a report containing
11 the results of the study conducted under paragraph
12 (1), including recommendations for such legislation
13 and administrative action with respect to the process
14 for medical review implemented under subsection (z)
15 of section 1833 of the Social Security Act (42
16 U.S.C. 1395l) as the Comptroller General deter-
17 mines appropriate.

18 **SEC. 515. NATIONAL EXPANSION OF PRIOR AUTHORIZA-**
19 **TION MODEL FOR REPETITIVE SCHEDULED**
20 **NON-EMERGENT AMBULANCE TRANSPORT.**

21 (a) INITIAL EXPANSION.—

22 (1) IN GENERAL.—In implementing the model
23 described in paragraph (2) proposed to be tested
24 under subsection (b) of section 1115A of the Social
25 Security Act (42 U.S.C. 1315a), the Secretary of

1 Health and Human Services shall revise the testing
2 under subsection (b) of such section to cover, effective
3 not later than January 1, 2016, States located
4 in medicare administrative contractor (MAC) regions
5 L and 11 (consisting of Delaware, the District of
6 Columbia, Maryland, New Jersey, Pennsylvania,
7 North Carolina, South Carolina, West Virginia, and
8 Virginia).

9 (2) MODEL DESCRIBED.—The model described
10 in this paragraph is the testing of a model of prior
11 authorization for repetitive scheduled non-emergent
12 ambulance transport proposed to be carried out in
13 New Jersey, Pennsylvania, and South Carolina.

14 (3) FUNDING.—The Secretary shall allocate
15 funds made available under section 1115A(f)(1)(B)
16 of the Social Security Act (42 U.S.C.
17 1315a(f)(1)(B)) to carry out this subsection.

18 (b) NATIONAL EXPANSION.—Section 1834(l) of the
19 Social Security Act (42 U.S.C. 1395m(l)) is amended by
20 adding at the end the following new paragraph:

21 “(16) PRIOR AUTHORIZATION FOR REPETITIVE
22 SCHEDULED NON-EMERGENT AMBULANCE TRANS-
23 PORTS.—

24 “(A) IN GENERAL.—Beginning January 1,
25 2017, if the expansion to all States of the

1 model of prior authorization described in para-
 2 graph (2) of section 515(a) of the Medicare Ac-
 3 cess and CHIP Reauthorization Act of 2015
 4 meets the requirements described in paragraphs
 5 (1) through (3) of section 1115A(c), then the
 6 Secretary shall expand such model to all States.

7 “(B) FUNDING.—The Secretary shall use
 8 funds made available under section 1893(h)(10)
 9 to carry out this paragraph.

10 “(C) CLARIFICATION REGARDING BUDGET
 11 NEUTRALITY.—Nothing in this paragraph may
 12 be construed to limit or modify the application
 13 of section 1115A(b)(3)(B) to models described
 14 in such section, including with respect to the
 15 model described in subparagraph (A) and ex-
 16 panded beginning on January 1, 2017, under
 17 such subparagraph.”.

18 **SEC. 516. REPEALING DUPLICATIVE MEDICARE SEC-**
 19 **ONDARY PAYOR PROVISION.**

20 (a) IN GENERAL.—Section 1862(b)(5) of the Social
 21 Security Act (42 U.S.C. 1395y(b)(5)) is amended by in-
 22 serting at the end the following new subparagraph:

23 “(E) END DATE.—The provisions of this
 24 paragraph shall not apply to information re-

1 quired to be provided on or after July 1,
2 2016.”.

3 (b) **EFFECTIVE DATE.**—The amendment made by
4 subsection (a) shall take effect on the date of the enact-
5 ment of this Act and shall apply to information required
6 to be provided on or after January 1, 2016.

7 **SEC. 517. PLAN FOR EXPANDING DATA IN ANNUAL CERT**
8 **REPORT.**

9 Not later than June 30, 2015, the Secretary of
10 Health and Human Services shall submit to the Com-
11 mittee on Finance of the Senate, and to the Committees
12 on Energy and Commerce and Ways and Means of the
13 House of Representatives—

14 (1) a plan for including, in the annual report of
15 the Comprehensive Error Rate Testing (CERT) pro-
16 gram, data on services (or groupings of services)
17 (other than medical visits) paid under the physician
18 fee schedule under section 1848 of the Social Secu-
19 rity Act (42 U.S.C. 1395w–4) where the fee sched-
20 ule amount is in excess of \$250 and where the error
21 rate is in excess of 20 percent; and

22 (2) to the extent practicable by such date, spe-
23 cific examples of services described in paragraph (1).

1 **SEC. 518. REMOVING FUNDS FOR MEDICARE IMPROVE-**
 2 **MENT FUND ADDED BY IMPACT ACT OF 2014.**

3 Section 1898(b)(1) of the Social Security Act (42
 4 U.S.C. 1395iii(b)(1)), as amended by section 3(e)(3) of
 5 the IMPACT Act of 2014 (Public Law 113–185), is
 6 amended by striking “\$195,000,000” and inserting “\$0”.

7 **SEC. 519. RULE OF CONSTRUCTION.**

8 Except as explicitly provided in this subtitle, nothing
 9 in this subtitle, including the amendments made by this
 10 subtitle, shall be construed as preventing the use of notice
 11 and comment rulemaking in the implementation of the
 12 provisions of, and the amendments made by, this subtitle.

13 **Subtitle B—Other Provisions**

14 **SEC. 521. EXTENSION OF TWO-MIDNIGHT PAMA RULES ON**
 15 **CERTAIN MEDICAL REVIEW ACTIVITIES.**

16 Section 111 of the Protecting Access to Medicare Act
 17 of 2014 (Public Law 113–93; 42 U.S.C. 1395ddd note)
 18 is amended—

19 (1) in subsection (a), by striking “the first 6
 20 months of fiscal year 2015” and inserting “through
 21 the end of fiscal year 2015”;

22 (2) in subsection (b), by striking “March 31,
 23 2015” and inserting “September 30, 2015”; and

24 (3) by adding at the end the following new sub-
 25 section:

1 “(c) CONSTRUCTION.—Except as provided in sub-
 2 sections (a) and (b), nothing in this section shall be con-
 3 strued as limiting the Secretary’s authority to pursue
 4 fraud and abuse activities under such section 1893(h) or
 5 otherwise.”.

6 **SEC. 522. REQUIRING BID SURETY BONDS AND STATE LI-**
 7 **CENSURE FOR ENTITIES SUBMITTING BIDS**
 8 **UNDER THE MEDICARE DMEPOS COMPETI-**
 9 **TIVE ACQUISITION PROGRAM.**

10 (a) BID SURETY BONDS.—Section 1847(a)(1) of the
 11 Social Security Act (42 U.S.C. 1395w–3(a)(1)) is amend-
 12 ed by adding at the end the following new subparagraphs:

13 “(G) REQUIRING BID BONDS FOR BIDDING
 14 ENTITIES.—With respect to rounds of competi-
 15 tions beginning under this subsection for con-
 16 tracts beginning not earlier than January 1,
 17 2017, and not later than January 1, 2019, an
 18 entity may not submit a bid for a competitive
 19 acquisition area unless, as of the deadline for
 20 bid submission, the entity has obtained (and
 21 provided the Secretary with proof of having ob-
 22 tained) a bid surety bond (in this paragraph re-
 23 ferred to as a ‘bid bond’) in a form specified by
 24 the Secretary consistent with subparagraph (H)
 25 and in an amount that is not less than \$50,000

1 and not more than \$100,000 for each competi-
2 tive acquisition area in which the entity submits
3 the bid.

4 “(H) TREATMENT OF BID BONDS SUB-
5 MITTED.—

6 “(i) FOR BIDDERS THAT SUBMIT BIDS
7 AT OR BELOW THE MEDIAN AND ARE OF-
8 FERED BUT DO NOT ACCEPT THE CON-
9 TRACT.—In the case of a bidding entity
10 that is offered a contract for any product
11 category for a competitive acquisition area,
12 if—

13 “(I) the entity’s composite bid
14 for such product category and area
15 was at or below the median composite
16 bid rate for all bidding entities in-
17 cluded in the calculation of the single
18 payment amounts for such product
19 category and area; and

20 “(II) the entity does not accept
21 the contract offered for such product
22 category and area,
23 the bid bond submitted by such entity for
24 such area shall be forfeited by the entity
25 and the Secretary shall collect on it.

1 “(ii) TREATMENT OF OTHER BID-
2 DERS.—In the case of a bidding entity for
3 any product category for a competitive ac-
4 quisition area, if the entity does not meet
5 the bid forfeiture conditions in subclauses
6 (I) and (II) of clause (i) for any product
7 category for such area, the bid bond sub-
8 mitted by such entity for such area shall
9 be returned within 90 days of the public
10 announcement of the contract suppliers for
11 such area.”.

12 (b) STATE LICENSURE.—

13 (1) IN GENERAL.—Section 1847(b)(2)(A) of the
14 Social Security Act (42 U.S.C. 1395w-3(b)(2)(A)) is
15 amended by adding at the end the following new
16 clause:

17 “(v) The entity meets applicable State
18 licensure requirements.”.

19 (2) CONSTRUCTION.—Nothing in the amend-
20 ment made by paragraph (1) shall be construed as
21 affecting the authority of the Secretary of Health
22 and Human Services to require State licensure of an
23 entity under the Medicare competitive acquisition
24 program under section 1847 of the Social Security

1 Act (42 U.S.C. 1395w-3) before the date of the en-
2 actment of this Act.

3 (c) GAO REPORT ON BID BOND IMPACT ON SMALL
4 SUPPLIERS.—

5 (1) STUDY.—The Comptroller General of the
6 United States shall conduct a study that evaluates
7 the effect of the bid surety bond requirement under
8 the amendment made by subsection (a) on the par-
9 ticipation of small suppliers in the Medicare
10 DMEPOS competitive acquisition program under
11 section 1847 of the Social Security Act (42 U.S.C.
12 1395w-3).

13 (2) REPORT.—Not later than 6 months after
14 the date contracts are first awarded subject to such
15 bid surety bond requirement, the Comptroller Gen-
16 eral shall submit to Congress a report on the study
17 conducted under paragraph (1). Such report shall
18 include recommendations for changes in such re-
19 quirement in order to ensure robust participation by
20 legitimate small suppliers in the Medicare DMEPOS
21 competition acquisition program.

22 **SEC. 523. PAYMENT FOR GLOBAL SURGICAL PACKAGES.**

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

1 “(8) GLOBAL SURGICAL PACKAGES.—

2 “(A) PROHIBITION OF IMPLEMENTATION
3 OF RULE REGARDING GLOBAL SURGICAL PACK-
4 AGES.—

5 “(i) IN GENERAL.—The Secretary
6 shall not implement the policy established
7 in the final rule published on November
8 13, 2014 (79 Fed. Reg. 67548 et seq.),
9 that requires the transition of all 10-day
10 and 90-day global surgery packages to 0-
11 day global periods.

12 “(ii) CONSTRUCTION.—Nothing in
13 clause (i) shall be construed to prevent the
14 Secretary from revaluing misvalued codes
15 for specific surgical services or assigning
16 values to new or revised codes for surgical
17 services.

18 “(B) COLLECTION OF DATA ON SERVICES
19 INCLUDED IN GLOBAL SURGICAL PACKAGES.—

20 “(i) IN GENERAL.—Subject to clause
21 (ii), the Secretary shall through rule-
22 making develop and implement a process
23 to gather, from a representative sample of
24 physicians, beginning not later than Janu-
25 ary 1, 2017, information needed to value

1 surgical services. Such information shall
2 include the number and level of medical
3 visits furnished during the global period
4 and other items and services related to the
5 surgery and furnished during the global
6 period, as appropriate. Such information
7 shall be reported on claims at the end of
8 the global period or in another manner
9 specified by the Secretary. For purposes of
10 carrying out this paragraph (other than
11 clause (iii)), the Secretary shall transfer
12 from the Federal Supplemental Medical In-
13 surance Trust Fund under section 1841
14 \$2,000,000 to the Center for Medicare &
15 Medicaid Services Program Management
16 Account for fiscal year 2015. Amounts
17 transferred under the previous sentence
18 shall remain available until expended.

19 “(ii) REASSESSMENT AND POTENTIAL
20 SUNSET.—Every 4 years, the Secretary
21 shall reassess the value of the information
22 collected pursuant to clause (i). Based on
23 such a reassessment and by regulation, the
24 Secretary may discontinue the requirement
25 for collection of information under such

1 clause if the Secretary determines that the
2 Secretary has adequate information from
3 other sources, such as qualified clinical
4 data registries, surgical logs, billing sys-
5 tems or other practice or facility records,
6 and electronic health records, in order to
7 accurately value global surgical services
8 under this section.

9 “(iii) INSPECTOR GENERAL AUDIT.—
10 The Inspector General of the Department
11 of Health and Human Services shall audit
12 a sample of the information reported under
13 clause (i) to verify the accuracy of the in-
14 formation so reported.

15 “(C) IMPROVING ACCURACY OF PRICING
16 FOR SURGICAL SERVICES.—For years beginning
17 with 2019, the Secretary shall use the informa-
18 tion reported under subparagraph (B)(i) as ap-
19 propriate and other available data for the pur-
20 pose of improving the accuracy of valuation of
21 surgical services under the physician fee sched-
22 ule under this section.”.

23 (b) INCENTIVE FOR REPORTING INFORMATION ON
24 GLOBAL SURGICAL SERVICES.—Section 1848(a) of the

1 Social Security Act (42 U.S.C. 1395w-4(a)) is amended
2 by adding at the end the following new paragraph:

3 “(9) INFORMATION REPORTING ON SERVICES
4 INCLUDED IN GLOBAL SURGICAL PACKAGES.—With
5 respect to services for which a physician is required
6 to report information in accordance with subsection
7 (c)(8)(B)(i), the Secretary may through rulemaking
8 delay payment of 5 percent of the amount that
9 would otherwise be payable under the physician fee
10 schedule under this section for such services until
11 the information so required is reported.”.

12 **SEC. 524. EXTENSION OF SECURE RURAL SCHOOLS AND**
13 **COMMUNITY SELF-DETERMINATION ACT OF**
14 **2000.**

15 (a) PAYMENTS FOR FISCAL YEARS 2014 AND
16 2015.—

17 (1) PAYMENTS REQUIRED.—Section 101 of the
18 Secure Rural Schools and Community Self-Deter-
19 mination Act of 2000 (16 U.S.C. 7111) is amended
20 by striking “2013” both places it appears and in-
21 serting “2015”.

22 (2) PROMPT PAYMENT.—Payments for fiscal
23 year 2014 under title I of the Secure Rural Schools
24 and Community Self-Determination Act of 2000 (16
25 U.S.C. 7111 et seq.), as amended by this section,

1 shall be made not later than 45 days after the date
2 of the enactment of this Act.

3 (3) REDUCTION IN FISCAL YEAR 2014 PAY-
4 MENTS ON ACCOUNT OF PREVIOUS 25- AND 50-PER-
5 CENT PAYMENTS.—Section 101 of the Secure Rural
6 Schools and Community Self-Determination Act of
7 2000 (16 U.S.C. 7111) is amended by adding at the
8 end the following new subsection:

9 “(c) SPECIAL RULE FOR FISCAL YEAR 2014 PAY-
10 MENTS.—

11 “(1) STATE PAYMENT.—If an eligible county in
12 a State that will receive a share of the State pay-
13 ment for fiscal year 2014 has already received, or
14 will receive, a share of the 25-percent payment for
15 fiscal year 2014 distributed to the State before the
16 date of the enactment of this subsection, the amount
17 of the State payment shall be reduced by the
18 amount of that eligible county’s share of the 25-per-
19 cent payment.

20 “(2) COUNTY PAYMENT.—If an eligible county
21 that will receive a county payment for fiscal year
22 2014 has already received a 50-percent payment for
23 that fiscal year, the amount of the county payment
24 shall be reduced by the amount of the 50-percent
25 payment.”.

1 (4) SHARES OF CALIFORNIA STATE PAY-
2 MENT.—Section 103(d)(2) of the Secure Rural
3 Schools and Community Self-Determination Act of
4 2000 (16 U.S.C. 7113(d)(2)) is amended by striking
5 “2013” and inserting “2015”.

6 (b) USE OF FISCAL YEAR 2013 ELECTIONS AND
7 RESERVATIONS FOR FISCAL YEARS 2014 AND 2015.—
8 Section 102 of the Secure Rural Schools and Community
9 Self-Determination Act of 2000 (16 U.S.C. 7112) is
10 amended—

11 (1) in subsection (b)(1), by adding at the end
12 the following new subparagraph:

13 “(C) EFFECT OF LATE PAYMENT FOR FIS-
14 CAL YEARS 2014 AND 2015.—The election other-
15 wise required by subparagraph (A) shall not
16 apply for fiscal year 2014 or 2015.”;

17 (2) in subsection (b)(2)—

18 (A) in subparagraph (A), by adding at the
19 end the following new sentence: “If such two-
20 fiscal year period included fiscal year 2013, the
21 county election to receive a share of the 25-per-
22 cent payment or 50-percent payment, as appli-
23 cable, also shall be effective for fiscal years
24 2014 and 2015.”; and

1 (B) in subparagraph (B), by striking
2 “2013” the second place it appears and insert-
3 ing “2015”; and
4 (3) in subsection (d)—

5 (A) by adding at the end of paragraph (1)
6 the following new subparagraph:

7 “(E) EFFECT OF LATE PAYMENT FOR FIS-
8 CAL YEAR 2014.—The election made by an eligi-
9 ble county under subparagraph (B), (C), or (D)
10 for fiscal year 2013, or deemed to be made by
11 the county under paragraph (3)(B) for that fis-
12 cal year, shall be effective for fiscal years 2014
13 and 2015.”; and

14 (B) by adding at the end of paragraph (3)
15 the following new subparagraph:

16 “(C) EFFECT OF LATE PAYMENT FOR FIS-
17 CAL YEAR 2014.—This paragraph does not apply
18 for fiscal years 2014 and 2015.”.

19 (c) SPECIAL PROJECTS ON FEDERAL LAND.—Title
20 II of the Secure Rural Schools and Community Self-Deter-
21 mination Act of 2000 (16 U.S.C. 7121 et seq.) is amend-
22 ed—

23 (1) in section 203(a)(1) (16 U.S.C.
24 7123(a)(1)), by striking “September 30 for fiscal
25 year 2008 (or as soon thereafter as the Secretary

1 concerned determines is practicable), and each Sep-
2 tember 30 thereafter for each succeeding fiscal year
3 through fiscal year 2013” and inserting “September
4 30 of each fiscal year (or a later date specified by
5 the Secretary concerned for the fiscal year)”;

6 (2) in section 204(e)(3)(B)(iii) (16 U.S.C.
7 7124(e)(3)(B)(iii)), by striking “each of fiscal years
8 2010 through 2013” and inserting “fiscal year 2010
9 and fiscal years thereafter”;

10 (3) in section 207(a) (16 U.S.C. 7127(a)), by
11 striking “September 30, 2008 (or as soon thereafter
12 as the Secretary concerned determines is prac-
13 ticable), and each September 30 thereafter for each
14 succeeding fiscal year through fiscal year 2013” and
15 inserting “September 30 of each fiscal year (or a
16 later date specified by the Secretary concerned for
17 the fiscal year)”;

18 (4) in section 208 (16 U.S.C. 7128)—

19 (A) in subsection (a), by striking “2013”
20 and inserting “2017”; and

21 (B) in subsection (b), by striking “2014”
22 and inserting “2018”.

23 (d) COUNTY FUNDS.—Section 304 of the Secure
24 Rural Schools and Community Self-Determination Act of
25 2000 (16 U.S.C. 7144) is amended—

1 (1) in subsection (a), by striking “2013” and
2 inserting “2017”; and

3 (2) in subsection (b), by striking “2014” and
4 inserting “2018”.

5 (e) AUTHORIZATION OF APPROPRIATIONS.—Section
6 402 of the Secure Rural Schools and Community Self-De-
7 termination Act of 2000 (16 U.S.C. 7152) is amended by
8 striking “for each of fiscal years 2008 through 2013”.

9 **SEC. 525. EXCLUSION FROM PAYGO SCORECARDS.**

10 (a) STATUTORY PAY-AS-YOU-GO SCORECARDS.—The
11 budgetary effects of this Act shall not be entered on either
12 PAYGO scorecard maintained pursuant to section 4(d) of
13 the Statutory Pay-As-You-Go Act of 2010.

14 (b) SENATE PAYGO SCORECARDS.—The budgetary
15 effects of this Act shall not be entered on any PAYGO
16 scorecard maintained for purposes of section 201 of S.
17 Con. Res. 21 (110th Congress).

○