

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.

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## 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

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## 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 information 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 certain 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 selection.  
 Sec. 208. Extension of funding outreach and assistance for low-income programs.  
 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 Indians.  
 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 METHODOLOGY.—Section 1848 of the Social Security Act  
 9 (42 U.S.C. 1395w-4) is amended—  
 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—

1 (A) in paragraph (1)(A), by adding at the  
2 end the following: “There shall be two separate  
3 conversion factors for each year beginning with  
4 2026, one for items and services furnished by  
5 a qualifying APM participant (as defined in  
6 section 1833(z)(2)) (referred to in this sub-  
7 section as the ‘qualifying APM conversion fac-  
8 tor’) and the other for other items and services  
9 (referred to in this subsection as the ‘nonquali-  
10 fying APM conversion factor’), equal to the re-  
11 spective conversion factor for the previous year  
12 (or, in the case of 2026, equal to the single con-  
13 version factor for 2025) multiplied by the up-  
14 date established under paragraph (20) for such  
15 respective conversion factor for such year.”;

16 (B) in paragraph (1)(D), by inserting “(or,  
17 beginning with 2026, applicable conversion fac-  
18 tor)” after “single conversion factor”; and

19 (C) by striking paragraph (16) and insert-  
20 ing the following new paragraphs:

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

1 would otherwise apply for 2015 for the period begin-  
2 ning on January 1, 2015, and ending on June 30,  
3 2015, the update to the single conversion factor  
4 shall be 0.0 percent.

5 “(17) UPDATE FOR JULY THROUGH DECEMBER  
6 OF 2015.—The update to the single conversion factor  
7 established in paragraph (1)(C) for the period begin-  
8 ning on July 1, 2015, and ending on December 31,  
9 2015, shall be 0.5 percent.

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

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

18 “(20) UPDATE FOR 2026 AND SUBSEQUENT  
19 YEARS.—For 2026 and each subsequent year, the  
20 update to the qualifying APM conversion factor es-  
21 tablished under paragraph (1)(A) is 0.75 percent,  
22 and the update to the nonqualifying APM conversion  
23 factor established under such paragraph is 0.25 per-  
24 cent.”.

25 (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

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

3 (2) QUALITY REPORTING.—

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

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

11 (ii) in clause (ii)(II), by striking “and  
12 each subsequent year” and inserting “,  
13 2017, and 2018”.

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

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

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

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

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

4 (ii) in subsection (m)—

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

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

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

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

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

20 (3) VALUE-BASED PAYMENTS.—

21 (A) SUNSETTING SEPARATE VALUE-BASED  
22 PAYMENTS.—Clause (iii) of section  
23 1848(p)(4)(B) of the Social Security Act (42  
24 U.S.C. 1395w–4(p)(4)(B)) is amended to read  
25 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

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

6 “(vii) PARTIAL QUALIFYING APM PAR-  
7 TICIPANT CLARIFICATIONS.—

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

21 “(II) NOT ELIGIBLE FOR QUALI-  
22 FYING APM PARTICIPANT PAY-  
23 MENTS.—In no case shall an eligible  
24 professional who is a partial quali-  
25 fying APM participant, with respect

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

7 “(D) APPLICATION TO GROUP PRAC-  
8 TICES.—

9 “(i) IN GENERAL.—Under the MIPS:

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

20 “(II) OTHER PERFORMANCE CAT-  
21 EGORIES.—The Secretary may estab-  
22 lish and apply a process that includes  
23 features of the provisions of sub-  
24 section (m)(3)(C) for MIPS eligible  
25 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 categories, 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

1 measures list published under subpara-  
2 graph (D)(i) for such year and the list of  
3 quality measures described in subpara-  
4 graph (D)(vi) used by qualified clinical  
5 data registries under subsection (m)(3)(E).

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

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

22 “(I) The subcategory of expanded  
23 practice access, such as same day ap-  
24 pointments for urgent needs and after  
25 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-

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

7 “(II) CONTRACT AUTHORITY FOR  
8 CLINICAL PRACTICE IMPROVEMENT  
9 ACTIVITIES PERFORMANCE CAT-  
10 EGORY.—In applying subparagraph  
11 (B)(iii), the Secretary may contract  
12 with entities to assist the Secretary  
13 in—

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

17 “(bb) specifying criteria for  
18 such activities; and

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

22 “(III) CLINICAL PRACTICE IM-  
23 PROVEMENT ACTIVITIES DEFINED.—  
24 For purposes of this subsection, the  
25 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           required 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-

1           centages applicable under one or more of  
2           subclauses (I), (II), and (III) of clause (i)  
3           for such year shall be increased in a man-  
4           ner such that the total percentage points  
5           of the increase under this clause for such  
6           year equals the total number of percentage  
7           points reduced under the preceding sen-  
8           tence for such year.

9           “(F)     CERTAIN     FLEXIBILITY     FOR  
10           WEIGHTING PERFORMANCE CATEGORIES, MEAS-  
11           URES, AND ACTIVITIES.—Under the method-  
12           ology under subparagraph (A), if there are not  
13           sufficient measures and activities (described in  
14           paragraph (2)(B)) applicable and available to  
15           each type of eligible professional involved, the  
16           Secretary shall assign different scoring weights  
17           (including a weight of 0)—

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

24                   “(ii) for each measure and activity  
25                   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-

1           sionals having higher composite per-  
2           formance scores receiving higher ad-  
3           justment factors; and

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

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

25                   “(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.



1                   “(D) ESTABLISHMENT OF PERFORMANCE  
2                   THRESHOLDS.—

3                   “(i) PERFORMANCE THRESHOLD.—

4                   For each year of the MIPS, the Secretary  
5                   shall compute a performance threshold  
6                   with respect to which the composite per-  
7                   formance score of MIPS eligible profes-  
8                   sionals shall be compared for purposes of  
9                   determining adjustment factors under sub-  
10                  paragraph (A) that are positive, negative,  
11                  and zero. Such performance threshold for  
12                  a year shall be the mean or median (as se-  
13                  lected by the Secretary) of the composite  
14                  performance scores for all MIPS eligible  
15                  professionals with respect to a prior period  
16                  specified by the Secretary. The Secretary  
17                  may reassess the selection of the mean or  
18                  median under the previous sentence every  
19                  3 years.

20                  “(ii) ADDITIONAL PERFORMANCE  
21                  THRESHOLD FOR EXCEPTIONAL PERFORM-  
22                  ANCE.—In addition to the performance  
23                  threshold under clause (i), for each year of  
24                  the MIPS, the Secretary shall compute an  
25                  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 eli-  
14                       gible 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-

1 organizations, regional extension centers (as de-  
2 scribed in section 3012(c) of the Public Health  
3 Service Act), or regional health collaboratives)  
4 to offer guidance and assistance to MIPS eligi-  
5 ble professionals in practices of 15 or fewer pro-  
6 fessionals (with priority given to such practices  
7 located in rural areas, health professional short-  
8 age areas (as designated under in section  
9 332(a)(1)(A) of such Act), and medically under-  
10 served areas, and practices with low composite  
11 scores) with respect to—

12 “(i) the performance categories de-  
13 scribed in clauses (i) through (iv) of para-  
14 graph (2)(A); or

15 “(ii) how to transition to the imple-  
16 mentation of and participation in an alter-  
17 native payment model as described in sec-  
18 tion 1833(z)(3)(C).

19 “(B) FUNDING FOR TECHNICAL ASSIST-  
20 ANCE.—For purposes of implementing subpara-  
21 graph (A), the Secretary shall provide for the  
22 transfer from the Federal Supplementary Med-  
23 ical Insurance Trust Fund established under  
24 section 1841 to the Centers for Medicare &  
25 Medicaid Services Program Management Ac-

1 count of \$20,000,000 for each of fiscal years  
2 2016 through 2020. Amounts transferred under  
3 this subparagraph for a fiscal year shall be  
4 available until expended.

5 “(12) FEEDBACK AND INFORMATION TO IM-  
6 PROVE PERFORMANCE.—

7 “(A) PERFORMANCE FEEDBACK.—

8 “(i) IN GENERAL.—Beginning July 1,  
9 2017, the Secretary—

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

17 “(II) may make available con-  
18 fidential feedback to such profes-  
19 sionals on the performance of such  
20 professionals with respect to the per-  
21 formance categories under clauses (iii)  
22 and (iv) of such paragraph.

23 “(ii) MECHANISMS.—The Secretary  
24 may use one or more mechanisms to make  
25 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;

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

15 (iv) provide recommendations for opti-  
16 mizing the use of such technical assistance  
17 funds.

18 (B) STUDY TO EXAMINE ALIGNMENT OF  
19 QUALITY MEASURES USED IN PUBLIC AND PRI-  
20 VATE PROGRAMS.—

21 (i) IN GENERAL.—Not later than 18  
22 months after the date of the enactment of  
23 this Act, the Comptroller General of the  
24 United States shall submit to Congress a  
25 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-

1 section (q)(5)(B)(ii)(II)” after “Subject to subpara-  
2 graph (B)(ii)”.

3 (e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

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

8 “(c) PHYSICIAN-FOCUSED PAYMENT MODELS.—

9 “(1) TECHNICAL ADVISORY COMMITTEE.—

10 “(A) ESTABLISHMENT.—There is estab-  
11 lished an ad hoc committee to be known as the  
12 ‘Physician-Focused Payment Model Technical  
13 Advisory Committee’ (referred to in this sub-  
14 section as the ‘Committee’).

15 “(B) MEMBERSHIP.—

16 “(i) NUMBER AND APPOINTMENT.—  
17 The Committee shall be composed of 11  
18 members appointed by the Comptroller  
19 General of the United States.

20 “(ii) QUALIFICATIONS.—The member-  
21 ship of the Committee shall include indi-  
22 viduals with national recognition for their  
23 expertise in physician-focused payment  
24 models and related delivery of care. No  
25 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 GROUPER.—  
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

1 practitioner organizations, and other stake-  
2 holders for episode groups in addition to those  
3 posted pursuant to such subparagraph, and  
4 specific clinical criteria and patient characteris-  
5 tics to classify patients into—

6 “(i) care episode groups; and

7 “(ii) patient condition groups.

8 “(D) DEVELOPMENT OF PROPOSED CLAS-  
9 SIFICATION CODES.—

10 “(i) IN GENERAL.—Taking into ac-  
11 count the information described in sub-  
12 paragraph (B) and the information re-  
13 ceived under subparagraph (C), the Sec-  
14 retary shall—

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

21 “(II) assign codes to such  
22 groups.

23 “(ii) CARE EPISODE GROUPS.—In es-  
24 tablishing 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

1 (n)(9)(A), and input from the physician spe-  
2 cialty societies, applicable practitioner organiza-  
3 tions, and other stakeholders, including rep-  
4 resentatives of individuals entitled to benefits  
5 under part A or enrolled under this part.

6 “(3) ATTRIBUTION OF PATIENTS TO PHYSI-  
7 CIANS OR PRACTITIONERS.—

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

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

1           such as a physician or applicable practitioner  
2           who—

3                   “(i) considers themselves 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 themselves 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

1 Centers for Medicare & Medicaid Services an  
2 operational plan for the development of quality  
3 measures for use under the applicable provi-  
4 sions. Such plan shall be updated as appro-  
5 priate.

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

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

16 “(B) PRIORITIZATION.—

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

22 “(ii) CONSIDERATION.—In selecting  
23 measures for development under this sub-  
24 section, 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 INDI-**  
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 diselo-  
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 disclose 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

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

3 (7) ASSESSMENT FOR A BREACH.—

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

10 (i) an agreement between the Sec-  
11 retary and a qualified entity; and

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

14 (B) ASSESSMENT.—The assessment under  
15 subparagraph (A) shall be an amount up to  
16 \$100 for each individual entitled to, or enrolled  
17 for, benefits under part A of title XVIII of the  
18 Social Security Act or enrolled for benefits  
19 under part B of such title—

20 (i) in the case of an agreement de-  
21 scribed in subparagraph (A)(i), for whom  
22 the Secretary provided data on to the  
23 qualified entity under paragraph (2); and

24 (ii) in the case of an agreement de-  
25 scribed 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-



1           retary shall submit to Congress a report on  
2           mechanisms that would assist providers in com-  
3           paring and selecting certified EHR technology  
4           products. The report shall include information  
5           on the benefits of, and resources needed to de-  
6           velop and maintain, such mechanisms.

7           (4) DEFINITIONS.—In this subsection:

8                   (A) The term “certified EHR technology”  
9           has the meaning given such term in section  
10          1848(o)(4) of the Social Security Act (42  
11          U.S.C. 1395w-4(o)(4)).

12                   (B) The term “meaningful EHR user” has  
13          the meaning given such term under the Medi-  
14          care EHR incentive programs.

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

17                           (i) in the case of the Medicare pro-  
18                           gram under title XVIII of the Social Secu-  
19                           rity Act, the incentive programs under sec-  
20                           tion 1814(l)(3), section 1848(o), sub-  
21                           sections (l) and (m) of section 1853, and  
22                           section 1886(n) of the Social Security Act  
23                           (42 U.S.C. 1395f(l)(3), 1395w-4(o),  
24                           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;

1 (iv) that evaluates the patients, condi-  
2 tions, and clinical circumstances that could  
3 most benefit from remote patient moni-  
4 toring services; and

5 (v) that evaluates the challenges re-  
6 lated to establishing appropriate valuation  
7 for remote patient monitoring services  
8 under the Medicare physician fee schedule  
9 under section 1848 of the Social Security  
10 Act (42 U.S.C. 1395w-4) in order to accu-  
11 rately reflect the resources involved in fur-  
12 nishing such services.

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

15 (i) REMOTE PATIENT MONITORING  
16 SERVICES.—The term “remote patient  
17 monitoring services” means services fur-  
18 nished through remote patient monitoring  
19 technology.

20 (ii) REMOTE PATIENT MONITORING  
21 TECHNOLOGY.—The term “remote patient  
22 monitoring technology” means a coordi-  
23 nated system that uses one or more home-  
24 based or mobile monitoring devices that  
25 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 priate 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)”;

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-

1 graph (1) and section 1854(b)(1)(C) for the  
2 first 3 plan years under this part in the case of  
3 an MA plan to which deemed enrollment applies  
4 under section 1851(c)(4)—

5 “(i) such plan shall not be treated as  
6 a new MA plan (as defined in paragraph  
7 (3)(A)(iii)(II)); and

8 “(ii) in determining the star rating of  
9 the plan under subparagraph (A), to the  
10 extent that Medicare Advantage data for  
11 such plan is not available for a measure  
12 used to determine such star rating, the  
13 Secretary shall use data from the period in  
14 which such plan was a reasonable cost re-  
15 imbursement contract.”.

16 **SEC. 210. EXTENSION OF HOME HEALTH RURAL ADD-ON.**

17 Section 421(a) of the Medicare Prescription Drug,  
18 Improvement, and Modernization Act of 2003 (Public Law  
19 108–173; 117 Stat. 2283; 42 U.S.C. 1395fff note), as  
20 amended by section 5201(b) of the Deficit Reduction Act  
21 of 2005 (Public Law 109–171; 120 Stat. 46) and by sec-  
22 tion 3131(c) of the Patient Protection and Affordable  
23 Care Act (Public Law 111–148; 124 Stat. 428), is amend-  
24 ed by striking “January 1, 2016” and inserting “January  
25 1, 2018” each place it appears.

1                   **Subtitle B—Other Health**  
2                   **Extenders**

3   **SEC. 211. PERMANENT EXTENSION OF THE QUALIFYING IN-**  
4                   **DIVIDUAL (QI) PROGRAM.**

5           (a)           PERMANENT           EXTENSION.—Section  
6   1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C.  
7   1396a(a)(10)(E)(iv)) is amended by striking “(but only  
8   for premiums payable with respect to months during the  
9   period beginning with January 1998, and ending with  
10   March 2015)”.

11          (b) ALLOCATIONS.—Section 1933(g) of the Social Se-  
12   curity Act (42 U.S.C. 1396u–3(g)) is amended—

13                   (1) in paragraph (2)—

14                           (A) by striking subparagraphs (A) through  
15                           (H);

16                           (B) in subparagraph (V), by striking  
17                           “and” at the end;

18                           (C) in subparagraph (W), by striking the  
19                           period at the end and inserting a semicolon;

20                           (D) by redesignating subparagraphs (I)  
21                           through (W) as subparagraphs (A) through  
22                           (O), respectively; and

23                           (E) by adding at the end the following new  
24                           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. 254e-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. 254e-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) 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)”; and

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-



1 graph (5)” and inserting “the allotment in-  
2 crease factor under paragraph (6)”;

3 (iv) in paragraph (3)—

4 (I) by striking “paragraphs (4)  
5 and (6)” and inserting “paragraphs  
6 (5) and (7)”;

7 (II) by striking “the allotment  
8 increase factor under paragraph (5)”  
9 and inserting “the allotment increase  
10 factor under paragraph (6)”;

11 (v) in paragraph (5) (as redesignated  
12 by paragraph (1)(F)), by striking “para-  
13 graph (1), (2), or (3)” and inserting  
14 “paragraph (1), (2), (3), or (4)”;

15 (vi) in paragraph (7) (as redesignated  
16 by paragraph (1)(F)), by striking “subject  
17 to paragraph (4)” and inserting “subject  
18 to paragraph (5)”;

19 (vii) in paragraph (9), (as redesign-  
20 ated by paragraph (1)(F)), by striking  
21 “paragraph (3)” and inserting “paragraph  
22 (3) or (4)”.

23 (C) Section 2104(n)(3)(B)(ii) of such Act  
24 (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

1 as “Medicaid”) and the Children’s Health Insurance  
2 Program under title XXI of such Act (referred to in  
3 this section as “CHIP”) through the use of the Ex-  
4 press Lane option under section 1902(e)(13) of the  
5 Social Security Act (42 U.S.C. 1396a(e)(13));

6 (2) assesses the extent to which individuals so  
7 enrolled meet the eligibility requirements under Med-  
8 icaid or CHIP (as applicable); and

9 (3) provides data on Federal and State expendi-  
10 tures under Medicaid and CHIP for individuals so  
11 enrolled and disaggregates such data between ex-  
12 penditures made for individuals who meet the eligi-  
13 bility requirements under Medicaid or CHIP (as ap-  
14 plicable) and expenditures made for individuals who  
15 do not meet such requirements.

## 16 **TITLE IV—OFFSETS**

### 17 **Subtitle A—Medicare Beneficiary** 18 **Reforms**

#### 19 **SEC. 401. LIMITATION ON CERTAIN MEDIGAP POLICIES** 20 **FOR NEWLY ELIGIBLE MEDICARE BENE-** 21 **FICIARIES.**

22 Section 1882 of the Social Security Act (42 U.S.C.  
23 1395ss) is amended by adding at the end the following  
24 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-

1       plification program under such subsection so as to  
2       eliminate the coverage of the part B deductible for  
3       any medical supplemental policy sold or issued under  
4       such program to a newly eligible Medicare bene-  
5       ficiary on or after January 1, 2020.

6               “(4) TREATMENT OF REFERENCES TO CERTAIN  
7       POLICIES.—In the case of a newly eligible Medicare  
8       beneficiary, except as the Secretary may otherwise  
9       provide, any reference in this section to a medicare  
10       supplemental policy which has a benefit package  
11       classified as ‘C’ or ‘F’ shall be deemed, as of Janu-  
12       ary 1, 2020, to be a reference to a medicare supple-  
13       mental policy which has a benefit package classified  
14       as ‘D’ or ‘G’, respectively.

15               “(5) ENFORCEMENT.—The penalties described  
16       in clause (ii) of subsection (d)(3)(A) shall apply with  
17       respect to a violation of paragraph (1) in the same  
18       manner as it applies to a violation of clause (i) of  
19       such subsection.”.

20       **SEC. 402. INCOME-RELATED PREMIUM ADJUSTMENT FOR**  
21               **PARTS B AND D.**

22               (a) IN GENERAL.—Section 1839(i)(3)(C)(i) of the  
23       Social Security Act (42 U.S.C. 1395r(i)(3)(C)(i)) is  
24       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:

<b>“If the modified adjusted gross income is:</b>	<b>The applicable percentage is:</b>
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

1 (4) in paragraph (6), in the matter before sub-  
2 paragraph (A), by striking “2019” and inserting  
3 “2017”.

## 4 **Subtitle B—Other Offsets**

### 5 **SEC. 411. MEDICARE PAYMENT UPDATES FOR POST-ACUTE** 6 **PROVIDERS.**

7 (a) SNFs.—Section 1888(e) of the Social Security  
8 Act (42 U.S.C. 1395yy(e))—

9 (1) in paragraph (5)(B)—

10 (A) in clause (i), by striking “clause (ii)”  
11 and inserting “clauses (ii) and (iii)”;

12 (B) in clause (ii), by inserting “subject to  
13 clause (iii),” after “each subsequent fiscal  
14 year,”; and

15 (C) by adding at the end the following new  
16 clause:

17 “(iii) SPECIAL RULE FOR FISCAL  
18 YEAR 2018.—For fiscal year 2018 (or other  
19 similar annual period specified in clause  
20 (i)), the skilled nursing facility market bas-  
21 ket percentage, after application of clause  
22 (ii), is equal to 1 percent.”; and

23 (2) in paragraph (6)(A)(i), by striking “para-  
24 graph (5)(B)(ii)” and inserting “clauses (ii) and (iii)  
25 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”;

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-

1           essing edits) to help reduce the error rate of  
2           payments under this title. The amounts re-  
3           tained under the preceding sentence shall not  
4           exceed an amount equal to 15 percent of the  
5           amounts recovered under this subsection, and  
6           shall remain available until expended.

7           “(B) LIMITATION.—Except for uses that  
8           support claims processing (including edits) or  
9           system functionality for detecting fraud,  
10          amounts retained under subparagraph (A) may  
11          not be used for technological-related infrastruc-  
12          ture, capital investments, or information sys-  
13          tems.

14          “(C) NO REDUCTION IN PAYMENTS TO RE-  
15          COVERY AUDIT CONTRACTORS.—Nothing in  
16          subparagraph (A) shall reduce amounts avail-  
17          able for payments to recovery audit contractors  
18          under this subsection.”.

19 **SEC. 506. IMPROVING SENIOR MEDICARE PATROL AND**  
20 **FRAUD REPORTING REWARDS.**

21          (a) IN GENERAL.—The Secretary of Health and  
22          Human Services (in this section referred to as the “Sec-  
23          retary”) shall develop a plan to revise the incentive pro-  
24          gram under section 203(b) of the Health Insurance Port-  
25          ability 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(e)) 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 **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 sserting “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).

○