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SENATE

{ REPORT
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TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT TO REPEAL THE
MEDICARE SUSTAINABLE GROWTH RATE FORMULA AND TO IMPROVE
BENEFICIARY ACCESS UNDER THE MEDICARE PROGRAM, AND FOR
OTHER PURPOSES

JANUARY 16, 2014.—Ordered to be printed

Mr. BAUCUS, from the Committee on Finance,
submitted the following

R E P O R T

[To accompany S. 1871]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, having considered an original bill, S. 1871, to amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate formula and to improve beneficiary access under the Medicare program, and for other purposes, reports favorably thereon and recommends that the bill do pass.

I. BACKGROUND AND NEED FOR LEGISLATIVE ACTION

The Sustainable Growth Rate (SGR) formula—the mechanism that dictates Medicare payment updates for physicians and other practitioners, referred to as professionals—is fundamentally broken and must be repealed. Congress has spent nearly \$150 billion since 2003 on short-term overrides of payment cuts stipulated by the SGR. These overrides or “patches” have frustrated providers, threatened access for beneficiaries, and created a budgetary dilemma from which Congress has struggled to emerge.

The physician fee schedule can limit the amount Medicare pays for each service but it does not directly impact the volume of services provided. When the fee schedule was implemented in 1992, a Medicare volume performance standard (MVPS) was included, but it was not very effective in limiting total professional expenditures. The Balanced Budget Act of 1997 (BBA, P.L. 105–33) established the SGR to replace the MVPS and created a target rate of growth for Medicare professional expenditures. The intent was to adjust payments under the fee schedule according to how overall Medicare professional spending compares to an SGR “target.”

Generally, under the SGR formula, comparisons of actual versus target spending for both the current year as well as cumulatively (going back to 1996, the base year) will determine the magnitude and direction (positive or negative) of the update adjustment factor. For example, if current year comparisons as well as cumulative expenditures from the current period going back to 1996 are less than the cumulative spending target over the same period, the annual update is increased according to a statutory formula. If, however, spending exceeds the cumulative spending target over the same period, the SGR methodology necessitates fee schedule update reductions to bring spending back in line with the target growth rate.

Since 2002, professional spending has routinely exceeded the target set by the SGR, resulting in payment cuts under the formula. In 2002, Medicare professional payments were cut by 4.8%. In subsequent years, however, Congress approved overrides of the payment reductions required by the SGR without changing the underlying formula. The most recent override was approved in December of 2013 as part of the Bipartisan Budget Act of 2013 (BPBA, P.L. 113–67) and replaced the SGR-dictated payment reduction with a 0.5 percent update for three months, until March 31, 2014. If Congress does not act by this date, Medicare professional payment rates will be cut by over 20%.

Congress has implemented several initiatives to address the perverse incentives created by the Medicare fee-for-service (FFS) system. The Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109–432) established the physician quality reporting system (PQRS) that provides incentive payments to eligible professionals who report quality data to Medicare. The Affordable Care Act (ACA, P.L. 111–148) extended the PQRS incentive payment program and created the value-based payment modifier (VBM), a separate, budget-neutral payment modifier that adjusts payments under the Medicare physician fee schedule based on the relative quality and cost of care provided. The implementation of the VBM shifted Medicare from paying for reporting to paying for value.

Congress has also advanced the objectives of delivery system reform in multiple ways. The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111–5) authorized incentive payments to physicians who are meaningful users of certified electronic health record (EHR) technology. Meaningful users must demonstrate the ability to exchange electronic health information to improve health care quality and use EHR technology to report clinical quality measures. Additionally, the ACA established the Center for Medicare and Medicaid Innovation (CMMI) to test alternative payment models (APMs) like accountable care organizations, bundled payments, and patient-centered medical homes.

The Committee Bill would permanently repeal the SGR update mechanism and provide zero percent updates until 2023. It also would reform the physician fee schedule by consolidating existing quality programs to place greater focus on value over volume, and encourage participation in APMs being tested by CMMI. After 2023, health care professionals in APMs would receive an annual payment update of two percent; all other professionals would receive an update of one percent.

The Bill would also consolidate the three existing incentive programs into a budget-neutral value-based performance (VBP) incen-

tive program. Under this program, professionals would receive annual payment increases or decreases based on their performance. By combining the existing quality incentive programs into a comprehensive VBP program, the Committee Bill would further value-based purchasing within the Medicare program while maintaining and improving the efficiency of the underlying structure with which professionals are already familiar.

Professionals who receive a significant portion of their revenue from an APM(s) that involves a quality measurement component, use of certified EHR technology and involves either two-sided financial risk or is a Medicare or Medicaid medical home certified by the Chief Actuary of the Centers for Medicare & Medicaid Services (CMS) as reducing Medicare spending would receive a bonus payment starting in 2017 and be exempted from the VBP program.

The Committee Bill would fund measure development priorities for professionals to address the current gaps in quality programs and ensure meaningful measures on which to assess professionals. It would also involve the health care professional community in furthering the measurement of resource use.

The Committee Bill would encourage care management services for individuals with complex chronic care needs through the development of new payment codes for such services. It would also leverage physician-developed standard of care guidelines to avoid the provision of unnecessary services. The Bill would also improve the accuracy of the physician fee schedule by setting a target for correcting misvalued services.

Recognizing the role of quality and resource use data in helping consumers make informed purchasing decisions and helping professionals improve their performance, the Bill would expand the data available to qualified entities (QEs) for quality improvement activities as well as the information available on the Physician Compare website.

In addition to ending the cycle of temporary SGR patches, the Committee Bill addresses so-called health extenders that Congress addresses temporarily year after year. The Bill makes permanent policies to support rural and small hospitals, the floor on geographic adjustments to the component of professional payments that reflect the time and intensity associated with furnishing a service, the authority for special needs plans (SNPs) for patients in institutionalized settings, and funding for outreach and assistance to low-income Medicare beneficiaries. The Bill also temporarily extends payment increases for ground ambulance transportation, the authority for SNPs for patients who are eligible for Medicare and Medicaid and patients with specific, disabling chronic conditions, funding for states to pay Medicare Part B premiums for low-income qualifying individuals, additional funding for the transitional medical assistance program, a temporary extension of "Express Lane" eligibility determination, redirected funding to temporarily extend pediatric quality measures, and funding for the special diabetes programs authorized under the BBA. Finally, the Bill replaces some existing extender policies with new policies. Medicare cost contract plans would be required to convert to Medicare Advantage (MA) plans or contracts will be terminated. Additionally, the existing cap on therapy services would be eliminated and replaced with a medical review program for outpatient therapy services.

The Committee Bill also temporarily extends funding for several human services programs including abstinence education grants, the personal responsibility education program, family-to-family health information centers, and the health workforce demonstration project for low-income individuals.

LEGISLATIVE HISTORY AND COMMITTEE ACTION

The 113th Congress brought renewed commitment by the Senate Finance Committee to repeal and replace the flawed SGR update mechanism. Two factors reinvigorated the debate on replacing the SGR: the significantly reduced Congressional Budget Office score for repealing the SGR over ten years (\$116.5 billion compared to over \$300 two years earlier) and a bipartisan proposal reported out by the House Energy & Commerce Committee in July of 2013.

The Senate Finance Committee began working on professional payment reform in the spring of 2012. The Committee held three roundtable discussions to ask three important questions. First, the Committee invited former CMS Administrators Gail Wilensky, Bruce Vladeck, Thomas Scully, and Mark McClellan to explain the history of the SGR and why it did not work as intended. Second, the Committee invited senior leaders from commercial insurance plans to discuss what professional payment reforms are being used in the private sector. Third, the Committee invited leaders from the American Medical Association and diverse physician specialty groups to ask them what an ideal payment system would look like for professionals.

A key finding of the roundtable discussions was that Congress should improve the existing FFS payment system while seeking to implement APMs that reward value over volume. To this end, the Finance Committee held a hearing in May of 2013 with the Executive Director of the Medicare Payment Advisory Commission (MedPAC) and other experts to discuss possible improvements to the FFS professional payment system. Witnesses emphasized that, while APMs would provide better incentives to help professionals improve quality and contain resource use, policies including a focus on care coordination, harmonizing current payment adjustments, and providing feedback to professionals on resource use would help improve the existing FFS system. Two months later, the Committee held a hearing with Jon Blum, Deputy Administrator of CMS, to discuss quality improvement programs that CMS is already implementing within the FFS system and APMs being tested by the CMMI.

During this time, Chairman Baucus and Ranking Member Hatch sent a letter to the professional community. The Senators asked for recommendations on policies that would improve the valuation of professional services under the physician fee schedule, identify and reduce unnecessary utilization to improve health and reduce Medicare spending growth, and incentivize practices to undertake the structural and behavioral changes needed to participate in APMs. Committee staff reviewed over 130 responses from stakeholders.

Building on that effort, the bipartisan, bicameral staffs of the House Ways & Means and Senate Finance Committees developed a discussion draft of a policy to replace the SGR and shared it with stakeholders on October 31, 2013. The Committees collected feedback for two weeks; holding town hall meetings with stakeholders

and reviewing over 200 comment letters. Based on this feedback, the Committees made several modifications to the policy. These changes adjusted the timeline for implementation of several provisions within the legislation to reflect professionals' readiness for practice transformation.

By December, the Finance Committee was ready to act. The Chairman's Mark was released on December 10, 2013, two days prior to the Executive Session to consider what became the Committee Bill.

During the markup the Committee recognized that market consolidation among providers, hospitals, and payers is a pressing issue facing the US health care system. Market consolidation could, through unintended consequences, raise the cost of care and, potentially even decrease access for Medicare beneficiaries. Creating a comprehensive, systematic ongoing mechanism for collecting information about health care markets so that they may be monitored in a timely fashion should be a key priority for policymakers. The Committee expressed support for efforts by the Government Accountability Office (GAO) to analyze market trends in health care consolidation, along with any common contributing factors, and evaluate the availability and quality of current public and private data sources on hospital, physician practice, and health plan ownership, transactions, and commercial pricing. The Committee may consider the GAO's report in future policy discussions.

Members submitted 137 amendments to the Mark. A total of 26 amendments was accepted and incorporated into the Mark before the Executive Session began and another seven amendments were approved by voice vote during the markup. No roll call votes were conducted. The final vote to report the bill was approved by voice vote.

II. EXPLANATION OF THE BILL

TITLE I—MEDICARE PAYMENT FOR PHYSICIANS' SERVICES

SEC. 101. REPEALING THE SUSTAINABLE GROWTH RATE AND IMPROVING MEDICARE PAYMENT FOR PHYSICIANS' SERVICES

Present Law

Medicare payments for items and services furnished by physicians and other professionals are made on the basis of a fee schedule. The fee schedule assigns relative value units (RVUs) to each of the over 7,000 service codes that reflect professional work (i.e., time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative value for a service compares the RVUs for professional work, practice expense and malpractice expense with the corresponding RVUs for other services. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS). These RVUs are adjusted for geographic variation in input costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

CMS, which is responsible for maintaining and updating the fee schedule, continually modifies and refines the methodology for estimating RVUs. The American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) has historically pro-

vided advice and recommendations to CMS to assist in the assessments. CMS is required to review the RVUs at least every five years.

In determining adjustments to the RVUs, the Secretary of Health and Human Services (herein after “the Secretary”) has authority to adjust the number of RVUs for any service code to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary is required to publish an explanation of the basis for such adjustments. These adjustments are subject to budget neutrality. With the exception of certain expenditures that are exempt by statute, the adjustments may not cause the amount of expenditures made under the Medicare physician fee schedule to differ from year to year by more than \$20,000,000 from the expenditures that would have been incurred without such an adjustment.

The SGR, is a statutory method for determining the annual updates to the Medicare physician fee schedule. The SGR methodology was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians’ services.

Generally, under the SGR formula, comparisons of actual versus target spending for both the current year as well as cumulatively (going back to 1996, the base year) will determine the magnitude and direction (positive or negative) of the update adjustment factor. For example, if current year comparisons as well as cumulative expenditures from the current period going back to 1996 are less than the cumulative spending target over the same period, the annual update is increased according to a statutory formula. If, however, spending exceeds the cumulative spending target over the same period, the SGR methodology necessitates fee schedule update reductions to bring spending back in line with the target growth rate.

In the first few years of the SGR system, the actual expenditures did not exceed the targets and the updates to the physician fee schedule were positive. Beginning in 2002, the cumulative actual expenditures exceeded allowed targets, resulting in SGR—mandated reductions in the update adjustment factor, and the discrepancy has grown each year. With the exception of 2002, when a 4.8 percent decrease was applied, Congress has enacted a series of laws to override the reductions.

Most recently, in December of 2013, the BPBA included a Congressional override of the SGR-dictated payment reduction, instead providing for a 0.5 percent update for three months, until March 31, 2014. If Congress does not act by this date, Medicare professional payment rates will be cut by over 20%.

Over time, Congress has added provisions to the physician fee schedule intended to improve the quality of care delivered to Medicare beneficiaries and constrain the growth of Medicare spending for professional services. The TRHCA required the establishment of a PQRS that would include an incentive payment to eligible professionals who satisfactorily report data on quality measures, based on a percentage of the allowed Medicare charges for all such covered professional services. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110–275) made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5 percent of total allowable

charges under the physician fee schedule in 2007 and 2008, and to two percent in 2009 and 2010.

The ACA extended the PQRS incentive payments through 2014 and put in place a penalty for providers who do not report quality measures beginning in 2015. Eligible professionals who successfully reported received a one percent bonus in 2011; those who successfully reported will receive a 0.5 percent bonus in 2012, 2013, and 2014. By contrast, eligible professionals who fail to participate successfully in the program face a 1.5 percent payment penalty in 2015, and a two percent payment penalty in 2016 and subsequent years. The incentive payments and penalties are based on the allowed charges for all covered services furnished by the eligible professional.

Both MedPAC and the GAO have suggested that CMS provide information to physicians on their resource use with the expectation that physicians who are outliers would alter their practice patterns in response. To that end, section 131 of the MIPPA established a physician feedback program. The physician feedback program uses Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. CMS initially called this effort the Physician Resource Use Feedback Program, but has renamed this initiative the “Physician Resource Use Measurement and Reporting Program.”

The ARRA authorized Medicare incentive payments over a five-year period to physicians who are determined to be “meaningful users” of certified EHR technology. Meaningful use is defined as (1) demonstrating to the satisfaction of the Secretary the use of certified EHR technology in a meaningful manner (including e-prescribing), including for the purpose of exchanging electronic health information to improve health care quality; and (2) using such certified EHR technology to report clinical quality measures, as selected by the Secretary. The incentive payments equal 75 percent of the allowed Part B charges during the reporting year. The total amount that a physician could receive was capped and decreased over time. Beginning in 2011, eligible physicians received up to \$15,000 in the first payment year, \$12,000 in the second year, \$8,000 in the third year, \$4,000 in the fourth year, and \$2,000 in the fifth, and final, year. Early EHR adopters whose first payment year was 2011 or 2012 received up to \$18,000 (instead of \$15,000) for that year.

Eligible physicians who become meaningful EHR users for the first time after 2013 will receive fewer payments and those who do not adopt EHRs until after 2014 will receive no bonus. No incentive payments will be made after 2016. Eligible physicians who are not meaningful EHR users by 2015 will see their Medicare payments reduced by the following amounts: one percent in 2015, two percent in 2016, three percent in 2017 and each subsequent year. For 2018 and each subsequent year, if the proportion of eligible physicians who are meaningful EHR users is less than 75 percent, the payment will be further decreased by one percentage point from the applicable amount in the previous year, though the reduction cannot exceed five percent. The Secretary may, on a case-by-case basis, exempt eligible physicians (e.g., rural physicians who lack suffi-

cient Internet access) from the payment reduction for up to five years if it is determined that being a meaningful EHR user would result in significant hardship.

The ACA required the Secretary to establish a VBM, which is a budget-neutral payment modifier that adjusts payments under the Medicare physician fee schedule based on the relative quality and cost of the care provided. Quality of care is to be evaluated on a composite of risk-adjusted measures of quality established by the Secretary, such as measures that reflect health outcomes. Costs, defined as expenditures per individual, are to be evaluated based on a composite of appropriate measures of costs established by the Secretary that eliminate the effect of geographic adjustments in payment rates and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and the health status of individuals) and other factors determined appropriate by the Secretary.

Beginning January 1, 2015, the value-based payment modifier will apply for items and services furnished for physicians in groups of 100 or more eligible professionals who submit claims to Medicare under a single tax identification number (TIN) based on performance in CY2013. In CY2015 one percent of payment will be at risk. This will increase to two percent in CY2016. By 2017, the value-based payment modifier will apply to all physicians who participate in FFS Medicare. The Secretary is to apply the payment modifier in a manner that promotes systems-based care and takes into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

Committee Bill

The Committee Bill would repeal the SGR methodology for determining updates to the Medicare physician fee schedule. In addition, it would: (1) provide a 10-year period of zero percent updates; (2) establish a value-based performance program that consolidates and enhances existing incentive payment programs; (3) incentivize the development of, and participation in, APMs; and (4) make other changes to Medicare physician payment policies.

The update to the conversion factor for the Medicare physician fee schedule would be zero percent for each year from 2014 through 2023. Beginning in 2024 and in subsequent years, the update would vary, depending on whether the provider is a participant in a qualifying APM. For services furnished by a qualifying APM participant, the update would be two percent, while the update for all other services provided by all other professionals would be one percent.

By July 1, 2016, MedPAC would be required to submit a report to Congress on the relationship between (1) physician and other health professional utilization and expenditures, and the rate of increase of such utilization and expenditures of items and services paid for under Part B of the Medicare program, and (2) total utilization and expenditures and their rates of increase under Medicare Parts A, B, and D. The report would include a methodology to describe this relationship and the impact of changes in practice and service ordering patterns of physician and other health professionals on total utilization and expenditures, of health care services

in Medicare Parts A, B, and D. Another report, applying the methodology developed, would be due to Congress by July 1, 2020.

The Committee Bill would create a new incentive payment system, which would be called the VBP incentive program. This program would extend key components of three existing programs and would sunset their payment incentives and separate application by consolidating and incorporating them into the new VBP program beginning on January 1, 2017 (the payment incentives for these programs would continue to be in effect for CY2015 and CY2016). These three programs are: (1) the Medicare EHR incentive program for meaningful use of certified EHR technology, (2) the quality reporting incentive program (currently called the PQRS), and (3) the value-based payment modifier. The VBP would continue to use the provisions and processes of these programs including meaningful use determinations already carried out by the Medicare program, PQRS quality metrics already being reported by professionals, and requirements for quality and resource use measurement under the VBM. Adjustments in the application of these provisions would be made to ensure consistency with the new VBP program to avoid duplicative requirements.

The VBP program would develop a methodology for assessing the total performance of each VBP eligible professional, provide for a composite performance score for each eligible professional for each performance period; and use the composite performance score of the VBP eligible professional to make VBP program incentive payments.

The VBP program would apply to payments for items and services furnished on or after January 1, 2017.

The types of health care professionals eligible for the VBP incentive payments would expand over time. Subject to the exclusions described below, physicians (as defined under section 1861(r) of the Social Security Act (SSA, P.L. 74-271)), physician assistants, nurse practitioners, and clinical nurse specialists (defined under section 1861(aa)(5) of the SSA), and certified clinical nurse specialists (defined under section 1861(bb)(2) of the SSA), and certified registered nurse anesthetists (defined under section 1861(bb)(2) of the SSA) would be eligible for the VBP program in 2017 and 2018. The Secretary would have the authority to expand the VBP program to additional eligible professionals described under section 1848(k)(3)(B) of the SSA, in 2019 and subsequent years.

Health care professionals excluded from the VBP program would include otherwise eligible professionals who are qualifying APM participants, partial qualifying APM participants who do not report on the applicable measures and activities (partial qualifying APM participants, who chose to report under the VBP program despite this exclusion, would be eligible for VBP incentive payments) and professionals who do not exceed the low-volume threshold.

The Secretary would select one of three low-volume thresholds to determine exclusion from the VBP program: (1) a minimum number of Medicare beneficiaries who are treated by the eligible professional, (2) a minimum number of items and services furnished by the professional to Medicare beneficiaries, or (3) a minimum amount of Medicare allowed charges billed by the professional. In each case, the minimum number would be determined by the Secretary.

A new VBP-eligible professional who had not previously submitted Medicare claims as a person, an entity, or as a part of a physician group or under a different billing number or tax identifier, would be eligible for the VBP incentive program beginning in the subsequent year and performance period for such year.

Payments to professionals who are not VBP eligible professionals would not be affected by any reduction in payments for establishment of the funding pool for VBP incentive payments or by any VBP program incentive payments.

The Secretary would encourage the use of qualified clinical data registries (as specified in current law) in carrying out this program.

The VBP program would be based on measures and activities under four categories. A composite performance score would be calculated for each VBP eligible professional, which would be used to determine the VBP program incentive payment amounts. The Secretary would use the following performance categories to determine the composite performance score and the measures and activities specified for each category:

1. Quality—The quality performance category would use quality measures established under current law for the PQRS program and the value—based payment modifier. The Secretary would, as feasible, emphasize the application of outcome measures, and could use measures used for a payment system other than for physicians or use global measures, such as global outcome measures, and population-based measures. Analysis of measures used under the quality performance category could include data submitted by VBP eligible professionals from multiple payers.

2. Resource use—The resource use performance category would use measures of resource use established under current law for the value—based payment modifier. To the extent feasible, resource use measures would account for the cost of Part D drugs. As appropriate, the Secretary would employ resource use measurements developed through the process for collaborating with the physician, practitioner, and other stakeholder communities to improve resource use measurement described below.

3. Clinical practice improvement activities—The clinical practice improvement activities performance category would use activities specified by the Secretary, including at least the following subcategories:

- (a) expanded practice access, which would include activities such as same-day appointments for urgent needs and after-hours access to clinician advice;

- (b) population management, which would include activities such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry;

- (c) care coordination, which would include activities such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth;

- (d) beneficiary engagement, which would include activities such as the establishment of care plans for individuals with complex care needs, beneficiary self-management training, and using shared decision-making mechanisms;

(e) patient safety and practice assessment, which would include activities such as the use of clinical or surgical checklists and practice assessments related to maintaining certification; and

(f) participation in an APM, as defined below.

In establishing the clinical practice improvement activities, the Secretary would give consideration to the circumstances of small practices consisting of ten or fewer professionals and practices located in rural areas and in health professional shortage areas (HPSA). The Secretary could contract with entities to assist in identifying the activities, specifying criteria for such activities, and determining whether a VBP eligible professional meets such criteria. Additionally, the Secretary would use a request-for-information process to solicit recommendations from stakeholders for identifying other activities not expressly listed above, and specifying criteria for such activities.

4. Meaningful use of certified EHR technology—The EHR Meaningful Use performance category would use requirements established for purposes of section 1848(o) of the SSA for determining whether an eligible professional is a meaningful EHR user for such period.

The Secretary would establish performance standards with respect to the measures and activities under each of the four VBP performance categories. The performance standards would take into account historical performance standards, improvement rates, and the opportunity for continued improvement.

The Secretary would establish a performance period (or periods) for each year in which incentive payments would be made under the VBP program, beginning with 2017. The performance period would begin and end prior to the beginning of the year in which the incentive payments would be paid and be as close as possible to the payment year.

With respect to assessing performance in the quality performance category, the Secretary would be required to establish and apply a process for applying the VBP program to group practices, which would include features of provisions that currently apply to group practices in the PQRS. With respect to assessing performance of group practices in the remaining three performance categories described above, the Secretary could also apply such a process for groups. In determining these processes, the Secretary would reflect the full range of items and services furnished by the VBP eligible professionals in the group practice involved, to the extent practicable. VBP eligible professionals electing to be a virtual group (as described below) would not be considered VBP eligible professionals in a group practice.

The Secretary would develop a methodology for assessing the total performance of each VBP eligible professional according to the performance standards and the applicable measures and activities specified above with respect to each performance category applicable to an eligible professional for a performance period. Using the methodology developed, the Secretary would determine a composite performance score for each such professional for each performance period.

In weighting the performance categories, measures, and activities to determine the composite performance score, the Secretary

may assign different scoring weights (including a weight of zero) for each performance category based on the extent to which the category is applicable to the type of eligible professional involved, and each measure and activity based on the extent to which the measure or activity is applicable to the type of eligible professional involved. With respect to the quality performance category, the Secretary would assign a higher scoring weight to outcomes measures than to other measures and increase the scoring weight for outcome measures over time. The Secretary could also assign a higher scoring weight to patient experience measures.

To incentivize reporting of activities and measures used to determine the composite performance score, a VBP eligible professional who failed to report on an applicable measure or activity that is required for such professional would be treated as having achieved the lowest potential score applicable. To encourage the use of certified EHR technology for reporting quality measures, the Secretary would encourage VBP eligible professionals to report on applicable quality measures through the use of certified EHR technology, and treat any VBP eligible professional who reports the applicable quality measures through the use of such EHR technology as having satisfied the clinical quality measures reporting requirement to be a meaningful EHR user under section 1848(o)(2)(A)(iii) of the SSA.

For the performance category of clinical practice improvement activities, a VBP eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice by an organization that is recognized by the Secretary for purposes of certifying medical homes and specialty practices would be given the highest potential score for the clinical practice improvement activities performance subcategory. A VBP eligible professional in an APM, as defined below, would earn one-half of the highest potential score for the clinical practice improvement activity performance category. Such professional could also earn more than one-half of the highest potential score for this performance period by performing additional activities with respect to the same performance category. A VBP eligible professional would not be required to perform activities in each subcategory of the clinical practice improvement activity performance category to achieve the highest potential score for this performance category.

The Secretary would ensure that the application of the methodology developed to determine the composite performance score would result in a continuous distribution of performance scores, which would subsequently result in differential incentive payments for VBP eligible professionals.

Beginning with the second year of the VBP program, in addition to the achievement score of a VBP eligible professional, the composite score methodology would take into account improvement in the quality performance and the resource use performance categories, and could take into account improvement in the other performance categories. Beginning with the fourth year of the VBP program, the composite score methodology would assign a higher scoring weight with respect to the achievement score than to any improvement score with respect to a measure or activity, or a performance category or both.

In general, subject to the adjustment noted below, the composite performance score would be determined based on the following weights: quality (30 percent), resource use (30 percent), clinical practice improvement activities (15 percent), and meaningful use of EHR technology (25 percent). In any year in which the Secretary estimates that the proportion of eligible professionals who are meaningful EHR users is 75 percent or greater, the Secretary could reduce the percent applicable from 25 percent, but not below 15 percent. If the Secretary were to make such a reduction, the weights of the other categories would be increased such that the total percentage points of the increase would equal the total number of percentage points by which the EHR category was to be reduced.

The weights for the quality and resource use performance categories would always be equal, even after the application of the above EHR adjustment, with the following exception. For the first two years of the VBP program, after any EHR adjustment, the Secretary could increase the weight for either the quality or the resource use performance category, as long as the Secretary were to decrease the weight under the other category by an equal number of percentage points and so long as neither weight is less than 15 percent.

The Secretary would provide a process to allow an individual VBP eligible professional or a group practice consisting of not more than ten VBP eligible professionals to elect to be a virtual group with at least one other individual VBP eligible professional or group of VBP eligible professionals. For VBP eligible professionals who elect to be a virtual group, the assessment on the quality and resource use performance categories applied to each professional in such group would be with respect to the combined performance of all such professionals in such group, and the composite score under the VBP program for each VBP eligible professional in the virtual group would be based on the assessment of the combined performance for the performance category and performance period.

VBP eligible professionals who elect to become a virtual group would be required to do so before the beginning of a performance period and would not be allowed to change status during the performance period. Each practice and each VBP eligible professional in such a practice could elect to be in no more than one virtual group for a performance period.

VBP incentive payments would be distributed in a budget neutral manner. The total amount for VBP program incentive payments for all VBP eligible professionals for a year would be equal to the total amount of the performance funding pool for all VBP eligible professionals (described below).

For items and services furnished by a VBP eligible professional, the Secretary would conduct two concurrent calculations to determine the amount paid: (1) a reduction of the otherwise applicable fee schedule amount for that year (see the applicable percent for the performance funding pool described below); and (2) a calculation of the VBP incentive payment amount (also described below). Eligible professionals would be notified of their payment adjustment prior to the year in which payments are made. The process to calculate the VBP incentive payment amount would not author-

ize or create an upfront withhold of reimbursements to eligible professionals.

The pool for paying VBP incentive payments would be created by reducing the otherwise applicable fee schedule amount, which is defined as the fee schedule amount for items and services furnished by an eligible professional that would otherwise apply. Beginning with 2017, the fee schedule amount for items and services provided by a VBP eligible professional would be reduced by the specified percentage described below (called the ‘applicable percent’). The cumulative amount of such reductions for a year across all VBP eligible professionals would constitute the ‘performance funding pool’ for the year. The applicable percent reduction would be 4 percent for 2017, 6 percent for 2018, 8 percent for 2019, 10 percent for 2020, and in subsequent years, a percentage to be specified by the Secretary, but no less than 10 percent and no more than 12 percent.

The Secretary would specify a VBP program incentive payment adjustment factor for each VBP eligible professional for a year, which would be determined by the composite performance score of the eligible professional for the year. The adjustment factors would result in differential payments reflecting the full range of distribution of composite performance scores of VBP eligible professionals with professionals having higher composite performance scores receiving higher payments. The adjustment factors in a year could not result in a payment reduction that exceeds the applicable percent for a year, and could not result in a payment increase that exceeds the applicable percent for such year.

The VBP program incentive payment amount for items and services furnished by a VBP eligible professional during a year would be equal to the difference between:

1. the product of (a) the VBP program incentive payment adjustment factor and (b) the otherwise applicable fee schedule amount; and
2. the otherwise applicable fee schedule amount, as reduced by the applicable percent above, with respect to such items and services, eligible professional, and year.

No later than 60 days prior to the year involved, the Secretary would make available to each VBP eligible professional the VBP program incentive payment adjustment factor and the percentage payment reduction for the performance funding pool applicable to the eligible professional for items and services furnished by the professional as described above for the year. The Secretary could include such information in confidential feedback reports.

The VBP program incentive payment and the payment reduction would each apply only with respect to the year involved. The Secretary would not take VBP program incentive payments or payment reductions into account in making payments to a VBP eligible professional in a subsequent year.

The Secretary would make information regarding the performance of VBP eligible professionals under the VBP program available to the public, in an easily understandable format on the Physician Compare website. This information would include the composite score for each VBP eligible professional, the performance of each VBP eligible professional with respect to each performance category, and the names of eligible professionals in qualifying

APMs and, to the extent feasible, the name of the APM. The information could also include the performance of each VBP eligible professional with respect to each performance category measure or activity. The Secretary would provide an opportunity for an eligible professional to review, and submit corrections to, the individual's information to be made public prior to such information being made public.

The Secretary would periodically post aggregate information on the VBP program on the Physician Compare website, including the range of composite scores for all VBP eligible professionals, and the range of the performance of all VBP eligible professionals with respect to each performance category.

The Secretary would consult with stakeholders in carrying out the VBP program, including for the identification of performance category measures and activities and the methodologies for developing the composite score and the VBP program incentive payment adjustment factors. These consultations would include the use of a request for information or other mechanisms determined appropriate.

The Secretary would enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers, or regional health collaboratives) to offer guidance and assistance to VBP eligible professionals in practices of ten or fewer professionals (with priority given to practices in rural areas, in HPSAs, in medically underserved areas, or with low composite scores). The guidance and assistance would help professionals comply with the VBP program, and transition to an APM.

For purposes of implementing the guidance and assistance described above, the Secretary would provide for the transfer of \$25 million from the Supplementary Medical Insurance (SMI) Trust Fund to the CMS Program Management Account for each of fiscal years 2014 through 2018. Not less than \$10 million would be available for technical assistance to practices of ten or fewer professionals in HPSAs. These amounts would be available until expended.

Beginning July 1, 2015, the Secretary would make available timely (such as quarterly) confidential feedback to each VBP eligible professional on the individual's performance with respect to the quality and resource use performance categories. The Secretary could also make available confidential feedback on the individual's performance with respect to the clinical practice improvement activities performance category and the meaningful use of certified EHR technology category. The Secretary could use one or more mechanisms to provide this feedback, including use of a web-based portal or other mechanisms determined appropriate by the Secretary. The Secretary would encourage provision of feedback through qualified clinical data registries under the existing PQRS program, as implemented by American Taxpayer Relief Act (ATRA, P.L. 112-240). The Secretary could also use such mechanisms to receive information from professionals.

To facilitate timely feedback, the Secretary could use data, with respect to VBP eligible professionals, from periods prior to the current performance period and could use rolling periods in order to make illustrative calculations about the performance of these pro-

professionals. This feedback would be exempt from disclosure under the Freedom of Information Act (FOIA, P.L. 104–231).

Beginning July 1, 2016, the Secretary would make available, to each VBP eligible professional, information about selected items and services (as determined appropriate by the Secretary) furnished to the professional's patients by other suppliers and providers of services for which Medicare payment is made. Information on selected items and services furnished to patients of a VBP eligible professional by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), would include the name of such providers furnishing items and services to such patients during the period, the types of items and services so furnished, and the dates on which these items and services were furnished. The Secretary would also make available historical averages (and other measures of the distribution if appropriate) of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary) for care episode codes for such period. Such information would be made available to VBP eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information would be made available on the same or similar terms as data are made available to accountable care organizations under section 1899 of the SSA, including a beneficiary opt-out.

The Secretary would establish a process under which a VBP eligible professional could seek an informal review of the calculation of the individual's VBP program incentive payment adjustment factor. The results of such a review would not be taken into account for purposes of determining the VBP program incentive payment adjustment factors with respect to a year (other than with respect to the calculation of such eligible professional's VBP program incentive payment adjustment factor for such year).

When considering how to implement the Committee Bill, the Secretary should consider the administrative impact on eligible professionals. Implementation of the Bill should not create any undue or complicated administrative burdens for eligible professionals.

There would be no administrative or judicial review of the following: (1) the methodology used to determine the amount of the VBP program incentive payment adjustment factor and the determination of such amount; (2) the determination of the amount of funding available for such VBP program incentive payments and the payment reduction described above; (3) the establishment of the performance standards and the performance period; (4) the identification of performance category measures and activities and information made public or posted on the Physician Compare website; and (5) the methodology developed and used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.

The GAO would submit two VBP program evaluation reports to Congress, due October 1, 2018 and October 1, 2021. These reports would include an examination of the distribution of the performance and incentive payments for VBP eligible professionals and patterns relating to the performance and incentive payments, including an analysis based on the type of provider, practice size, geographic location, and patient mix. The reports would also provide

recommendations for improving the program. Finally, the reports would evaluate the impact of technical assistance funding on the ability of providers (especially physicians in rural areas or HPSAs, and physicians treating other underserved populations) to improve within the VBP or successfully transition to APMs and provide recommendations for maximizing use of these technical assistance funds.

The GAO would submit reports to Congress on October 1, 2019 and October 1, 2021 on the transition of physicians in rural areas and HPSAs and physicians treating other underserved populations to APMs. The studies would make recommendations on changes that could be made to overcome barriers for rural providers and those in HPSAs to participate in APMs.

The GAO would also submit a report to Congress, not later than 18 months after enactment, which would compare the similarities and differences in the use of quality measures under the Medicare FFS program, the MA program, selected state Medicaid programs, and private payer arrangements. The report would consider those measures applicable to Medicare enrollees under the age of 65 and would focus on measures that comprise the most significant component of the quality performance category of the VBP program. The report would also make recommendations on how to reduce the administrative burden involved in applying such quality measures.

For purposes of implementing the VBP program, the Secretary would provide for the transfer from the SMI Trust Fund to the CMS Program Management Account of \$50 million for each fiscal year from 2014 through 2017. Amounts transferred would remain available until expended.

The Committee Bill includes several modifications to improve quality reporting for the VBP program. The Bill clarifies and allows group practices to meet satisfactory reporting requirements for group practices by reporting to qualified clinical data registries beginning in 2015 and subsequent years. Similarly, current requirements for satisfactory reporting under the PQRS program are simplified, beginning in 2014 and in subsequent years, by allowing (but not requiring) the Secretary to establish alternative criteria for satisfactorily reporting such as reporting groups of measures under the PQRS program and to establish an alternative reporting period. The satisfactory reporting of measures for group practices would be modified for 2014 and subsequent years by allowing for, but not requiring, the use of a statistical sampling model to submit data on measures.

Reports under the physician feedback program would not be provided after December 31, 2016 and instead would be provided under the requirements of the VBP program (described above).

The Committee Bill establishes incentive payments for eligible professionals who become qualifying participants in an eligible APM. For covered professional services furnished by a qualifying APM participant from 2017 through 2022, such professionals would be paid an amount equal to five percent of the payment amount for the Medicare-covered professional services for the preceding year (which may be an estimate for the full preceding year based on a period that is less than the full year). The Secretary would establish policies to implement the additional payment in cases where payment for covered professional services furnished by a qualifying

APM participant in an APM is made to an entity participating in the APM rather than directly to the participant. Payment would be made in a lump sum, on an annual basis, as soon as practicable. APM incentive payments would not be taken into account for purposes of determining actual expenditures or rebasing any benchmarks used under the APM.

The amount of the additional payment for an item or service made to a qualifying APM participant would be determined without regard to additional payments for items and services furnished to professionals in HPSAs (under section 1833(m) of the SSA), additional incentive payments for primary care services (under section 1833(x) of the SSA), or additional incentive payments for major surgical procedures furnished in HPSAs (under section 1833(y) of the SSA).

The term “APM” would be defined to mean any of the following:

- (a) A model under the CMMI defined under section 1115A of the SSA (other than a health care innovation award).
- (b) A Medicare Shared Savings Program accountable care organization (defined under section 1899 of the SSA).
- (c) A demonstration under section 1866(C) of the SSA.
- (d) A demonstration required by federal law.

The term “eligible APM” would mean, with respect to a year, an APM that uses certified EHR technology (defined under section 1848(o)(4) of the SSA), provides for payment for covered professional services based on quality measures comparable to the VBP quality performance category, and satisfies the requirement that the APM (1) bears financial risk for monetary losses under such model that are in excess of a nominal amount or (2) is a medical home expanded under the CMMI (under section 1115A(c) of the SSA).

The term “qualifying APM participant” would mean the following:

- (1) in 2017 and 2018, an eligible professional for whom the Secretary determines that at least 25 percent of payments for Medicare-covered professional services furnished by the professional during the most recent period for which data are available (which may be less than a year) were attributable to services furnished to individuals who receive services under Medicare Part B through an entity that participates in an eligible APM;

- (2) in 2019 and 2020, an eligible professional for whom the Secretary determines that:

- a. Medicare-only revenue threshold option—at least 50 percent of payments under Medicare Part B for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to services furnished to individuals who receive services under Medicare Part B through an entity that participates in an eligible APM; or
- b. Medicare and all-payer revenue threshold option—
 - i. at least 25 percent of payments under this part were for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to service furnished to individuals who receive serv-

ices under Medicare Part B through an entity that participates in an eligible APM;

ii. at least 50 percent of the sum of payments made under Medicare Part B, and all other payments regardless of payer (other than payments made by the Veterans Administration, TRICARE, or payments made under title XIX in the case where no medical home or APM is available under the State program under that title) for items and services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such items and services for which such professional uses certified EHR technology (as defined under section 1848(o)(4) of the SSA), is paid based on quality measures comparable to the VBP quality performance category, and satisfies the requirement that the APM (1) bears more than nominal financial risk if aggregate expenditures exceeds expected aggregate expenditures or (2) is a title XIX medical home meeting criteria comparable to medical homes expanded under section 1115A(c); and

iii. who provides the Secretary such information as is necessary for the Secretary to make a determination regarding the percent of revenue received under (ii) above.

(3) in 2021 and subsequent years, an eligible professional for whom the Secretary determines that:

a. Medicare only revenue threshold option—at least 75 percent of payments under Medicare Part B for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to services furnished to individuals who receive services under Medicare Part B through an entity that participates in an eligible APM;

b. Medicare and all-payer revenue threshold option—

i. at least 25 percent of payments under this part were for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to items and services furnished to individuals who receive services under Medicare Part B through an entity that participates in an eligible APM;

ii. at least 75 percent of the sum of payments made under Medicare Part B, and all other payments regardless of payer (other than payments made by the Veterans Administration, TRICARE, or payments made under title XIX in the case where no medical home or APM is available under the State program under that title) for items and services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such items and services for which such professional uses certified EHR technology (as defined under section 1848(o)(4) of the SSA), is paid based on quality measures comparable to the VBP quality performance category, and satisfies the requirement that the APM (1) bears more than nominal financial risk if aggregate expenditures exceeds expected aggregate

expenditures or (2) is a title XIX medical home meeting criteria comparable to medical homes expanded under section 1115A(c); and

iii. who provides the Secretary such information as is necessary for the Secretary to make a determination regarding the percent of revenue received under (ii) above.

A “partial qualifying APM participant” would be defined as an eligible professional who would fail to meet the appropriate revenue threshold to achieve a bonus payment under the qualified APM program but who met the thresholds defined below. Although a partial qualifying APM participant could choose to participate in the VBP program for a year (and receive VBP incentive payments for that year), the eligible professional would be held harmless for lack of participation in the VBP program if the appropriate revenue thresholds were met, as follows:

1. for 2017 and 2018, the partial qualifying APM threshold would be set at 20 percent of Medicare revenue;
2. for 2019 and 2020, the partial qualifying APM threshold would be set at 40 percent of Medicare revenue; or 40 percent of all-payer revenue and 20 percent of Medicare revenue; and
3. for 2021 and subsequent years, the partial qualifying APM threshold would be set at 50 percent of Medicare revenue or 50 percent of all-payer revenue and 20 percent of Medicare revenue.

The term “eligible professional” would have the same meaning as defined for purposes of the PQRS program (under section 1848(k)(3)(B) of the SSA).

There would be no administrative or judicial review of the following: (1) the determination that an eligible professional is a qualifying APM participant as described above and the determination that an APM is an eligible APM; and (2) the determination of the amount of the five percent payment incentive including any estimation as part of this determination.

The Committee Bill would not prevent an APM or qualifying APM participant from furnishing a telehealth service for which Medicare payment is not made.

To encourage the development and testing of additional APMs, section 1115A(b)(2) would be amended to encourage CMMI to test models focusing primarily on physicians’ services (as defined under section 1848(j)(3) of the SSA), with particular focus on services furnished by physicians who are not primary care practitioners, practices of ten or fewer professionals, statewide payment models, in addition to other public sector or private sector payers, and models that focus primarily on Medicaid, working in conjunction with the Center for Medicaid and CHIP Services.

In designing APMs under this section of the Committee Bill, to the extent an APM includes a product covered under Medicare Part D, the Secretary would take into consideration the successful Part D competitive bidding system.

The Secretary would propose to Congress a plan to integrate MA APMs that take into account a budget neutral VBM.

The Secretary would also conduct a study that examines the applicability of the federal fraud prevention laws to items and services furnished under the Medicare program for which payment is made under an APM. The study would identify aspects of APMs

that are vulnerable to fraudulent activities and examine the implications of waivers of federal fraud prevention laws granted by the Secretary in support of APMs (including any expansion of APMs).

Not later than two years after the date of enactment, the Secretary would report to Congress on the results of the study. The report would be required to include recommendations for actions to be taken to reduce vulnerability of APMs to fraudulent activities (including, as appropriate, recommendations of the Inspector General for changes in federal fraud prevention laws).

The Secretary would also conduct a study that examines the effect of individuals' socioeconomic status on quality and resource use outcome measures for individuals under the Medicare program. The study would collect information on factors such as urban and rural location, eligibility for Medicaid (recognizing and accounting for varying Medicaid eligibility across states), and eligibility for benefits under the Supplemental Security Income program. Not later than two years after the date of enactment, the Secretary would report to Congress on the results of the study.

The Secretary would also conduct another study examining the impact of risk factors described under the VBM established under the SSA, as well as other factors such as health literacy, limited English proficiency, patient activation, and race, on quality and resource use outcome measures under the Medicare program. In conducting the study, the Secretary could use existing federal data and collect additional data that may be necessary to complete the study. Not later than five years after the date of enactment, the Secretary would report to Congress on the results of the study.

In conducting the studies, the Secretary would examine other useful non-Medicare data sets such as data from the American Community Survey. The Secretary would also consider how such data sets can be coordinated with Medicare administrative data, in order to improve the overall data set available to complete the studies and for the administration of the Medicare program.

If the studies find a relationship between the factors examined and quality and resource use outcome measures, then the Secretary would also provide recommendations on how CMS should obtain access to the necessary data (and how to address barriers to data collection). The Secretary would also provide recommendations on how CMS should account for such factors in determining payment adjustments based on quality and resource use outcome measures under the VBP program and other similar provisions under the Medicare program.

To conduct these studies, \$6 million would be appropriated from the SMI Trust Fund to the Secretary. These funds would remain available until expended.

Taking into account the studies conducted and recommendations made, the Secretary, on an ongoing basis, would estimate how an individual's health status and other risk factors affect quality and resource use outcome measures and, as feasible, would incorporate information from quality and resource use outcome measurement (including care episode and patient condition groups) into the VBP program and, as the Secretary determines appropriate other similar provisions of the Medicare program.

Taking into account the studies conducted and recommendations made, the Secretary would account for factors identified with an ef-

fect on quality and resource use outcome measures when determining payment adjustments under the eligible professional VBP program and, as the Secretary determines appropriate, other similar Medicare provisions.

The Secretary would collect or obtain data necessary to account for factors besides health status. The Secretary would carry out periodic analyses, at least every three years, based on factors other than health status so as to monitor possible changes in relationships between factors examined and quality and resource use outcome measures.

To conduct these activities, \$10 million would be appropriated from the SMI Trust Fund to the Secretary. These funds would remain available until expended.

Not later than 18 months after the date of the enactment of the Committee Bill, the Secretary would develop and report to Congress on a strategic plan for collecting or otherwise accessing data on race and ethnicity for purposes of carrying out the Medicare program.

The Secretary would engage in a process, collaborating with physician, practitioner, and other stakeholder communities, to improve resource use measurement. The Secretary would be required to develop a classification system and codes in order to classify similar patients into distinct care episode and patient condition groups for purposes of measuring resource use. No later than 60 days after enactment, the Secretary would post a list on the CMS website of the episode groups and a related description of the grouping criteria developed pursuant to the episode grouper required under section 1848(n)(9)(A) of the SSA. The Secretary would accept suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for additional episode groups as well as specific clinical criteria and patient characteristics to classify similar patients into distinct care episode groups, and distinct patient condition groups after the Secretary posts the list to the CMS website for 60 days.

To develop the proposed classification codes, the Secretary would establish distinct care episode groups and distinct patient condition groups which account for at least an estimated two-thirds of expenditures under Medicare Parts A and B, and assign codes to these groups.

In establishing the care episode groups, the Secretary would base the groups on the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization is anticipated or occurs, the principal procedures or services planned or furnished, and other factors determined appropriate by the Secretary.

In establishing the patient condition groups, the Secretary would base the groups on the patient's clinical history at the time of each medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during the previous three months), and other factors determined appropriate by the Secretary (such as Medicare eligibility status and dual eligibility under Medicare and Medicaid).

The Secretary would be required to post a draft list of the care episode and patient condition codes (and the criteria and characteristics assigned to the codes) on the CMS website within 120 days after the stakeholder comment deadline. The Secretary would then seek comments from physician specialty societies, applicable practitioner organizations, and other stakeholders regarding the draft list and use one or more mechanisms that could include use of open door forums, town hall meetings, or other appropriate mechanisms.

Not later than 120 days after the end of the comment period, the Secretary would post an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to the code) on the CMS website, taking into account the comments received.

Beginning with 2016, the Secretary would formalize the update process and make appropriate revisions to the operational lists of care episode and patient condition codes by November 1 of each year, through rulemaking. Such revisions could be based on experience, new information developed pursuant to the development of the episode grouper required under section 1848(n)(9)(A) of the SSA, and input from physician specialty societies, applicable practitioner organizations, and other stakeholders.

To facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners who provided their care, the Secretary would undertake the following:

1. Develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of providing an item or service. These patient relationship categories would include different relationships of the physician or applicable practitioner to the patient (and the codes could reflect combinations of such categories), such as a physician or applicable practitioner who:

- a. considers themselves to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

- b. considers themselves to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

- c. furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

- d. furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

- e. furnishes items and services only as ordered by another physician or practitioner.

2. Post the draft list of patient relationship categories and codes on the CMS website within 180 days after the date of enactment.

3. Seek comments, through the date that is 60 days after the Secretary posts the list of draft patient relationship categories and codes, from physician specialty societies, applicable practitioner organizations, and other stakeholders regarding the patient relationship categories and codes as posted. In seeking such comments, the Secretary would use one or more mechanisms that may include

open door forums, town hall meetings, or other appropriate mechanisms.

4. Post an operational list of patient relationship categories and codes on the CMS website not later than 120 days after the end of the comment period, taking into account the comments received.

5. Make revisions to the operational list of patient relationship categories and codes as appropriate not later than November 1 of each year (beginning with 2016), through rulemaking. Such revisions could be based on experience, new information developed pursuant to the development of the episode grouper required under section 1848(n)(9)(A) of the SSA, and input from physician specialty societies, applicable practitioner organizations, and other stakeholders.

Beginning on January 1, 2016, any claim for payment for items or services furnished by a physician or applicable practitioner would have to include, as determined appropriate by the Secretary, care episode and patient condition codes and patient relationship codes, and the national provider identifier (NPI) of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

In order to evaluate the resources used to treat patients with respect to care episode and patient condition groups, the Secretary would conduct an analysis using the patient relationship codes reported on claims to attribute patients (in whole or in part) to one or more physicians and applicable practitioners, and using the care episode and patient condition codes reported on claims as a basis to compare similar patients and care episodes and patient condition groups.

This resource use analysis would, as feasible, use the claims data experience of patients during a common period, such as 12 months, for patient condition codes. In addition, the analysis would use the claims data experience by care episode codes for defined periods of time as determined appropriate by the Secretary. For non-hospitalization services, the defined period could be the number of days of care, while the period for episodes with a hospitalization could be the number of days before, during, and after the hospitalization.

In measuring the resource use, the Secretary would use per patient total allowed charges for all services under Medicare Part A, Part B and, if the Secretary determines appropriate, Part D, for the analysis of patient resource use, by care episode codes and by patient condition codes. The Secretary could use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes), as appropriate.

The Secretary would seek comments from physician specialty societies, applicable practitioner organizations, and other stakeholders regarding the resource use methodology established above. In seeking comments, the Secretary would use one or more mechanisms (other than notice and comment rulemaking) that could include open door forums, town hall meetings, or other appropriate mechanisms.

There would be no administrative or judicial review of the care episode and patient condition groups and codes, patient relationship categories and codes, or measurement of, and analyses of resource use with respect to, the care episode and patient condition codes and patient relationship codes.

CMS would not penalize any professional who fails to report information for the development of care episode, patient condition, and patient relationship codes with non-payment of a claim.

Requirements under current law (Chapter 35 of title 44, United States Code) regarding coordination of federal information, including the Paperwork Reduction Act, would not apply to this section.

For purposes of the resource use program described in this section, the term ‘physician’ would have the same meaning as under current Medicare law, while the term ‘applicable practitioner’ would mean (1) a physician assistant, nurse practitioner, or clinical nurse specialist (as such terms are defined under current law), and (2) beginning January 1, 2017, other eligible professionals as specified by the Secretary.

The Committee Bill process for collaborating with the physician, practitioner, and other stakeholder communities to measure resource use falls outside of the process of multi-stakeholder input for measure development.

SEC. 102. PRIORITIES AND FUNDING FOR QUALITY MEASURE DEVELOPMENT

Present Law

Currently, measures for physicians and practitioners are concentrated in certain specialties and services while other services and specialties have few or no measures. In addition, many current measures are process measures rather than the preferred type of measures such as for outcomes, functional status, patient experience, care coordination and measures of appropriate use of services.

Committee Bill

The Committee Bill would amend section 1848 of the SSA to add a new subsection (s), “Priorities and Funding for Quality Measure Development.” The Secretary would be required, not later than October 1, 2014, to develop a draft plan for the development of professional quality measures for application in the quality performance category under the new VBP program and comparable quality measures used by an APM. Such plan would be required to address how measures used in integrated delivery systems and by private payers could be incorporated under this subsection. In developing the plan, the Secretary would be required to consider gap analyses conducted by the entity with a contract under Section 1890(a) of the SSA or other contractors or entities and whether measures are applicable across health care settings. In addition, the Secretary would be required to prioritize, among other things, outcome measures, including patient-reported outcome and functional status measures, patient experience measures, care coordination measures, and measures of appropriate use of services (including measures of overuse).

The Secretary would be required to accept stakeholder comments on the draft plan, through December 1, 2014, and would be re-

quired to, not later than February 1, 2015, post on the CMS website an operational plan for the development of quality measures for use under the VBP.

Under the Committee Bill, the Secretary would also be required to enter into contracts or other arrangements with entities (such as physician specialty societies and other practitioner organizations) to develop, improve, update, or expand quality measures. In entering into contracts, the Secretary would be required to give priority to measures that are prioritized in the draft plan. In addition, the Secretary must consider whether measures developed would be electronically specified.

The Secretary would be required, not later than February 1, 2016 and annually thereafter, to post on the CMS website a report on the progress made in developing quality measures for application as specified. The reports would be required to include the following: (1) a description of the Secretary's efforts to implement the subsection; (2) for the measures developed over the previous year, including information on the total and type of measures developed, the name of each measure developed, the name of the developer and steward for each measure, and an estimate of the total amount expended to develop the measures (this information must also be provided for measures in development, as well as a timeline for development completion); (3) an update on the progress in developing measures of outcome, patient experience of care, care coordination, and appropriate use; (4) a list of topics and concepts that are being considered for development and the rationale for the selection of topics and concepts, including their relationship to gaps analyses; (5) a description of updates to the plan and the inventory of applicable measures maintained by CMS; and (6) other information the Secretary determines appropriate.

The Secretary would be required to seek stakeholder input with respect to: (1) the identification of gaps where no measures exist, and specifically with respect to measures of outcomes, patient experience of care, care coordination, and appropriate use; (2) prioritization of quality measure development to address such gaps; and other quality measure development areas, as determined by the Secretary.

To carry out these activities, the Secretary would provide for the transfer of \$15 million, for each of FY2014 through FY2018, from the SMI Trust Fund to the CMS Program Management Account. The funds would remain available through FY2021.

SEC. 103. ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS

Present Law

Physicians are paid under the physician fee schedule for services provided to Medicare beneficiaries. The most common services are for evaluation and management (E/M), which are often associated with a typical physician office visit. Generally, to receive payment, there must be a face-to-face visit with the patient. Beneficiaries with chronic care needs often require care management services. Payments for E/M visits are calculated to include some non-face-to-face care management. However, these codes do not reflect all of the services and resources required to furnish comprehensive co-

ordinated care management services for beneficiaries with chronic needs.

In the 2014 Medicare physician fee schedule final rule, CMS established a new payment for professionals for managing Medicare patients' chronic conditions in addition to payments professionals already receive for treating the patient's presenting condition. These new payments are separately payable for non-face-to-face chronic care management services. The chronic care management payment would apply to Medicare FFS beneficiaries with multiple chronic conditions expected to persist for at least 12 months or until the patient's death. The conditions must put patients at significant risk of death, acute exacerbation/decomposition, or functional decline. The new payment would be for 20-minutes of management services that physicians can deliver over a 30-day period.

Committee Bill

The Committee Bill directs the Secretary to establish one or more Healthcare Common Procedure Coding System (HCPCS) codes for chronic care management services for individuals with chronic care needs. The Secretary would make payment for such management services furnished on or after January 1, 2015 by an applicable provider.

The term applicable provider would refer to providers who furnish services as part of a patient-centered medical home or comparable specialty practice that is certified by an organization recognized by the Secretary, or who meet other comparable qualifications that the Secretary determines appropriate. Applicable providers eligible to receive care management payments include a doctor of medicine or osteopathy. The Committee Bill also defines an applicable provider as a physician assistant or nurse practitioner who performs such services as are legally authorized by the state. Finally, the Committee Bill recognizes clinical nurse specialists licensed to practice nursing in the state in which clinical nurse specialist services are performed as an applicable provider.

In establishing new HCPCS codes for chronic care management services, the budget neutrality provision of the physician fee schedule would still apply.

Payment for chronic care management services would only be made to one applicable provider during a period on behalf of each beneficiary. Payments for such management services could not be duplicative of payments for other services, such as hospice or home health services. Finally, payments for chronic care management would not require that an annual wellness visit or an initial preventive physician examination be furnished as a condition of payment.

The Bill directs the Secretary to conduct an education and outreach campaign to inform providers and individuals enrolled under Medicare Part B of the benefits of chronic care management. The campaign would encourage enrollees with chronic conditions to receive chronic care management services. The Secretary would work through the Office of Rural Health Policy of the Department of Health and Human Services and the Office of Minority Health of CMS and would focus on encouraging participation by underserved rural populations and racial and ethnic minority populations. The Secretary would report to Congress no later than December 31,

2017 on the use of chronic care management services by individuals living in rural areas and by racial and ethnic minority populations. The report would identify barriers to receiving chronic care management services and make recommendations for increasing the appropriate use of chronic care management services.

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

Present Law

Payment is made under the Medicare physician fee schedule for more than 7,000 services. Payment is equal to the sum of the RVUs—adjusted for geographic differences in costs—for physician work, practice expense, and malpractice for each service. A RVU reflects the relative resources of one physician fee schedule service compared to another.

The Secretary is responsible for establishing the fee schedule, including the modification and refinement of the methodology for establishing RVUs. In establishing RVUs, the Secretary receives recommendations from the public including the RUC. Modifications to RVUs for a service are done in a budget neutral manner. Thus, payment increases from changes to the RVUs for some services must be offset by reductions in payment for all other physicians' services. The Secretary is required to review the RVUs no less than every five years.

Currently, when the Secretary calculates RVUs, the results can be very minor relative value differences that do not reflect material differences in the work, practice expense and malpractice relative value difference. For example, the difference between 18.61 and 18.62 does not reflect a material difference between services.

Section 1848(c)(2)(K) of the SSA requires the Secretary to periodically identify physicians' services as being potentially misvalued, and to make appropriate adjustments to the RVUs of such services under the Medicare physician fee schedule. To identify potentially misvalued services, the Secretary is to examine codes (and families of codes as appropriate) with the fastest growth, that have experienced substantial changes in practice expenses, for new technologies or services, that are frequently billed in conjunction with furnishing a single service, with low relative values, particularly those that are often billed multiple times for a single treatment, that have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'), and other codes the Secretary determines appropriate.

In its March 2013 report, MedPAC recommended that Congress direct the Secretary to identify over-priced fee-schedule services and that the RVU reductions should achieve a target of 1 percent of fee-schedule spending for each of five consecutive years. MedPAC's recommendation stated that the reductions should be budget neutral within the fee schedule.

Committee Bill

Under the Committee Bill, the Secretary could collect information on the resources used by an eligible professional to provide services that are paid under the Medicare physician fee schedule. This information could be collected or obtained from any eligible

professional or any other source. The Secretary could use this information in the determination of relative values for physician services paid for under the physician fee schedule.

Under the Committee Bill, the Secretary could collect or obtain any or all of the following types of information: (1) the time to perform each service; (2) amounts and types of practice expense resources needed to perform each service; (3) the prices of practice expense resources needed to perform each service, which may include paid invoices or other documentation or records; (4) overhead and accounting information of physicians' practices; or (5) any other element that would improve the valuation of physician services.

The Secretary could use any of the following mechanisms to collect or obtain the information listed above: (1) surveys of physicians, other suppliers, providers, manufacturers and vendors; (2) surgical logs, billing systems, or other practice or facility records; (3) EHRs; and (4) other mechanisms determined appropriate by the Secretary.

The Secretary must report the source of information collected or obtained in the determination of relative values for physician services. The Secretary must also report how such information was used in the determination of relative values through notice and comment rulemaking. The Secretary may also exclude information collected or obtained from physicians who use a very high amount of resources to furnish services.

Information used to determine relative values for services that are reported by the Secretary will only be made available in aggregate form and will not disclose information that identifies an eligible professional or a group practice or information collected or obtained pursuant to a nondisclosure agreement. The Federal Information Policy (Chapter 35 of Title 44 of the US Code) will not apply to information collected or obtained.

In order to incentivize physicians to provide information, the Secretary could provide for payments to eligible professionals who submit information.

"Eligible professionals" are those that meet the definition of section 1848(k)(3)(B) of the SSA which includes: (1) physicians, (2) physician assistants, (3) nurse practitioners, (4) clinical nurse specialists, (5) certified registered nurse anesthetists, (6) certified nurse midwives, (7) clinical social workers, (8) clinical psychologists, (9) registered dietitian or nutrition professionals, (10) physical or occupational therapists, (11) qualified speech-language pathologists, and (12) qualified audiologists.

In addition to funds otherwise appropriated, the Secretary will provide for the transfer of \$2 million from the SMI Trust Fund to the CMS Program Management Account for each fiscal year beginning with FY 2014. Amounts transferred for a fiscal year will be available until expended.

There would be no administrative or judicial review of the collection and use of information in the determination of relative values.

The Secretary could use cost, charge, and other information collected or obtained from suppliers and providers to determine the practice expense relative values for physician services, including the new information collected under this provision.

The Committee Bill expands the criteria the Secretary must use for identifying potentially misvalued codes to (1) codes that account for the majority of spending under the physician fee schedule; (2) codes for services that have experienced a substantial change in the hospital length of stay or procedure time; (3) codes for which there may be a change in the typical site of service since the code was last valued; (4) codes for which there is a significant difference in payment for the same service between different sites of service; (5) codes for which there may be anomalies in relative values within a family of codes; (6) codes for services where there may be efficiencies when a service is furnished at the same time as other services; (7) codes with high intra-service work per unit of time; (8) codes with high practice expense RVUs; and (9) codes with high cost supplies.

With respect to fee schedules established for each year of 2015 through 2018, the Secretary must determine the estimated net reduction in expenditures under the fee schedule for a year as a result of adjustments to the relative values for misvalued codes. The Committee Bill sets a target of 0.5 percent of the estimated amount of expenditures under the fee schedule for each year of 2015 through 2018 for such reductions.

If the estimated net reduction in expenditures for the year is equal to or greater than the 0.5 percent target for the year, reduced expenditures attributable to such adjustments will be redistributed in a budget neutral manner within the physician fee schedule. Any reductions in excess of the target will be treated as a reduction in expenditures for purposes of meeting the target for the following year.

If the estimated net reduction in expenditures for the year is less than the 0.5 percent target, the difference between the target and the estimated net reduction in expenditures will not be subject to budget neutrality and fee schedule payments will be reduced by that difference.

Beginning in 2015, if the total reduction of the RVUs (including work, practice expense, and malpractice) for a service for a year is more than 20 percent of the total value of the RVUs for the previous year, the applicable reductions in work, practice expense, and malpractice RVUs will be phased in over a two-year period.

The Committee Bill would give the Secretary authority to smooth minor differences in relative values for families or groups of procedures.

Not later than one year after enactment, the GAO will conduct a study of the processes used by the RUC to provide recommendations to the Secretary regarding the relative values for specific services under the physician fee schedule.

SEC. 105. PROMOTING EVIDENCE-BASED CARE

Present Law

Medicare pays for outpatient imaging services through the physician fee schedule. Following findings from MedPAC, GAO, and others that the rate of growth in Medicare outpatient imaging services was greater than for most other Medicare covered services, Congress and CMS have initiated a number of policies to address the issue. The Deficit Reduction Act (DRA, P.L. 109–171) modified the

payment rules for certain imaging services by capping the technical component of the payment for services paid under the physician fee schedule at the level paid under the hospital outpatient prospective payment system (OPPS) effective January 1, 2007. Services subject to the cap are: X-rays, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy.

CMS, in the November 2005 physician fee schedule regulations, extended the multiple procedure payment reduction policy to certain imaging services. The payment reduction was 25 percent of the technical component of certain imaging procedures performed on contiguous body areas. Under section 1848(c)(2)(b)(vi) of the SSA the reduction is increased to 50 percent effective July 2010. CMS expanded the application of the payment reduction to studies on noncontiguous body areas and the professional component for the second and subsequent services to the same patient, in the same session, on the same day.

CMS's method for calculating the Medicare fee schedule reimbursement rate for advanced imaging services originally assumed that imaging machines are operated 25 hours per week, or 50 percent of the time that practices are open for business. Setting the equipment use factor at a lower rate has led to higher payment for these services. Citing evidence showing that the utilization rate is 90 percent, rather than the 50 percent previously assumed, MedPAC urged CMS to use the higher utilization rate in the calculation of fee schedule payments for advanced imaging services. The ACA changed the utilization rate assumption for calculating the payment for advanced imaging equipment from 50 percent, as assumed in prior years, to 75 percent for 2011 and subsequent years. The ATRA requires the Secretary to apply a 75 percent use rate in calculating payment rates for advanced imaging services through 2013, and a 90 percent use rate for 2014 and subsequent years.

To further address the rapid growth in advanced imaging services, MedPAC recommended, in its June 2011 report, that Congress direct the Secretary to establish a prior authorization program for practitioners who order substantially more advanced diagnostic imaging services than their peers.

Committee Bill

The Committee Bill would promote the use of evidence-based medical care. Specifically, it would create a program to promote utilization of appropriate use criteria by ordering professionals for certain imaging services in designated settings. Appropriate use criteria would be defined as criteria used to assist ordering professionals in making the most appropriate treatment decision for a specific clinical condition. The Committee Bill would require professionals to consult appropriate use criteria as a prerequisite to Medicare payment for the applicable imaging service.

The following professionals would be subject to these requirements: (1) medical doctors and osteopaths, (2) dentists, (3) podiatrists, (4) optometrists, (5) chiropractors, (6) physician assistants, (7) nurse practitioners, (8) clinical nurse specialists, (9) certified nurse anesthetists, (10) certified nurse-midwives, (11) clinical social workers, (12) clinical psychologists, and (13) registered dietitians or

nutritional professionals. Ordering professionals would be defined as professionals who order an applicable imaging service for an individual. Furnishing professionals would be defined as professionals who furnish an applicable imaging service for an individual.

Applicable imaging services would be defined as those advanced diagnostic imaging services defined in section 1834(e)(1)(B) of the SSA for which there are one or more appropriate use criteria specified by the Secretary through rulemaking and at least one or more qualified clinical decision support mechanisms that are free of charge.

These requirements would apply for diagnostic imaging services furnished in the following settings: (1) physicians' offices, (2) hospital outpatient departments (HOPD), (3) ambulatory surgical centers, (4) and any other provider-led outpatient setting determined appropriate by the Secretary. The Secretary could only choose appropriate use criteria developed or endorsed by national professional medical specialty societies or other provider-led entities. Applicable payment systems would be defined as the physician fee schedule, the OPPS, and the ambulatory surgical center payment system.

The Secretary would be required to specify appropriate use criteria by November 15, 2015 only from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other provider-led entities. This would be accomplished through rulemaking and in consultation with physicians, practitioners, and other stakeholders. In specifying these criteria, the Secretary would consider whether the criteria have achieved stakeholder consensus, are scientifically valid and evidenced-based, and are based on studies that are published and reviewable by stakeholders. The Secretary would periodically update and revise (as appropriate) the appropriate use criteria. In cases where more than one appropriate use criteria applies, the Secretary would specify one or more criteria that would be applicable.

In addition to these criteria, the Secretary would specify—in consultation with physicians, practitioners, and other stakeholders—one or more qualified clinical decision support mechanisms that could be used by ordering professionals to consult appropriate use criteria for the applicable imaging services. These mechanisms could include certified EHR clinical decision support modules, private sector clinical support tools that are independent from certified EHR technology, including clinical decision support mechanisms available from medical specialty organizations, and other clinical decision support mechanisms established by the Secretary.

To be qualified, the clinical decision support mechanism would have to be able to make available to the ordering physician the applicable appropriate use criteria and supporting documentation, and also be able to determine the extent to which the ordering of an applicable image complies with the criteria. In the case where there are more than one applicable appropriate use criteria specified for an applicable imaging service, the mechanism must be able to indicate which criteria it uses for the service. The mechanism would also be able to generate and provide to the ordering physician a certification or documentation that the criteria was consulted by the ordering physician. It would be updated on a regular basis to reflect revisions to the criteria, comply with all applicable

privacy and security standards, and be able to perform other functions specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering physician. The Secretary would provide a list of qualifying mechanisms by April 1, 2016 and update it periodically.

Beginning on January 1, 2017, an ordering professional in an applicable setting would consult appropriate use criteria via qualified clinical decision support mechanisms for applicable imaging services and provide the furnishing professional with the following: (1) information about which decision support mechanism was consulted by the ordering professional; (2) whether the ordered imaging service adhered to the applicable appropriate use criteria, did not adhere, or the criteria were not applicable to the service ordered; and (3) the NPI of the ordering professional (if different from the furnishing professional). Payment for the imaging service would only be made if the claim includes this information.

The appropriate use requirement would not apply to applicable imaging services ordered: (1) for individuals with an emergency medical condition, (2) for hospital inpatients, (3) by professionals in an APM, as defined under section 102 of the Committee Bill, and (4) by professionals who would face significant hardship consulting with appropriate use criteria, such as professionals whose practices are in a rural area without sufficient Internet access.

Using data from January 1, 2017 onward, the Secretary would periodically determine ordering professionals who are outliers based on their low adherence to applicable appropriate use criteria, which may be based on comparisons to other ordering professionals. The Secretary's determination would also include data for professionals who are subject to prior authorization. In making these determinations, the Secretary would use two years of data and consult with physicians, practitioners, and other stakeholders in developing methods to identify outlier professionals.

The Committee intends that the prior authorization program would reduce inappropriate use of applicable imaging services by professionals with a recent history of low adherence to applicable appropriate use criteria.

In developing this program, the Secretary should include a mechanism to support professionals who are outliers based on their low adherence to applicable appropriate use criteria to remove the outlier designation after demonstrating sufficient adherence to applicable appropriate use criteria.

The Committee intends the outlier provisions to apply to a small minority of total professionals.

Beginning on January 1, 2020, all applicable imaging services ordered by an outlier ordering professional would be subject to prior authorization. To fund this prior authorization program, \$5 million per year would be provided to CMS from the SMI Trust Fund from 2019 through 2021. Amounts transferred from the SMI Trust Fund would remain available until expended.

The Secretary could establish an appropriate use program for other services under Part B. Such process would replicate the provider-developed or provider-endorsed framework for appropriate use criteria for applicable imaging services described above. In determining whether to establish any additional programs, the Secretary would also take into consideration the results of a GAO

study—conducted 18 months after enactment—on the extent to which appropriate use criteria could be used for other services, such as radiation therapy and clinical diagnostic laboratory services. In addition, before issuing a proposed rule expanding appropriate use criteria to other Part B services, the Secretary would seek comments from stakeholders through an advance notice of proposed rulemaking.

The Committee Bill would not authorize the Secretary to initiate the development of clinical practice guidelines. The intent of the Committee Bill is to empower physicians and other professionals to lead and disseminate best practices that have been developed and accepted by the physician and professional stakeholder community.

SEC. 106. EMPOWERING BENEFICIARY CHOICES THROUGH ACCESS TO
INFORMATION ON PHYSICIANS' SERVICES

Present Law

Section 10331 of the ACA required the Secretary to develop, not later than January 1, 2011, a Physician Compare website with information about physicians enrolled in Medicare and other eligible professionals who participate in the Physician Quality Reporting Initiative (now the PQRS). The Secretary was required, by January 1, 2013, to implement a plan to make publicly available comparative information on physician performance on quality and patient experience measures (consistent with privacy protections codified at 5 U.S.C. § 552 and § 552a).

The information on Physician Compare is required to include, among other things, measures collected under PQRS, and an assessment of efficiency, safety, patient health outcomes, and patient experience. In developing and implementing this plan, the Secretary was required to consider a number of factors, including among others, processes to ensure appropriate attribution and processes to ensure that data made publicly available is statistically valid and reliable.

The Secretary is required to consider the feedback from the multi-stakeholder groups (consistent with sections 1890(b)(7) and 1890A of the SSA) when selecting measures for use under this section, and must consider the plan to transition to a value-based purchasing program for physicians (under section 131 of the MIPPA) when developing and implementing the plan under this section. The Secretary is required to report to Congress, not later than January 1, 2015, on the Physician Compare website. At any time before the submission of this report, the Secretary is authorized to expand the information available on the Physician Compare website to other types of Medicare providers, and is authorized to establish, at any time not later than January 1, 2019, a demonstration program to provide financial incentives to Medicare beneficiaries who utilize high quality physicians (as determined by the Secretary based on information included on the Physician Compare website).

Committee Bill

The Committee Bill would codify section 10331 of the ACA into the SSA by creating a new section 1848(t). It would also direct the Secretary to post additional information on Physician Compare on eligible professionals.

The Secretary would include the following information on Physician Compare: (1) information on the number of services provided by each eligible professional, which could include information on the most frequent services furnished or groupings of services, (2) information on submitted charges and payments for services under Medicare Part B, and (3) a publicly available and unique identifier, such as a national provider identifier, for each eligible professional.

Physician Compare would be searchable by at least (1) the specialty or type of eligible professional, (2) the characteristics of the services furnished, such as the volume or groupings of services, and (3) the location of the eligible professional.

Physician Compare would also indicate, where appropriate, that the publicized information may not be representative of the eligible professional's entire patient population, the variety of services provided by the eligible professional, or the health conditions of individuals treated.

The Secretary would make this information available on Physician Compare by July 1, 2015 for physicians and by July 1, 2016 for other eligible professionals. The Secretary would also update Physician Compare on at least an annual basis.

SEC. 107. EXPANDING CLAIMS DATA AVAILABILITY TO IMPROVE CARE

Present Law

Section 1874(e) of the SSA requires the Secretary to make claims data available that could be used to measure health care provider and supplier performance. This section enables QEs to obtain standardized extracts, as determined by the Secretary, of Medicare Parts A, B, and D claims data for one or more specified geographic areas and time periods. The fees for making Medicare data available for performance measurement are to be equal to the cost of providing the data. The Secretary must take those actions necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts. CMS created the QE Certification for Medicare Data Program and published a final rule that established regulations governing the program.

To be certified as a QE, entities must be qualified (as determined by the Secretary) to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use. They also must agree to requirements governing the use of the data.

QEs are only permitted to use the Medicare data for publishing public performance reports on providers and suppliers. When requesting the Medicare data, a QE must submit to the Secretary a description of the methodologies that will be used to evaluate provider performance. They must also combine the CMS-provided data with claims data from another source. When creating reports, they must use standard measures if available. However, if necessary, they may use alternative measures in consultation with appropriate stakeholders. Additionally, the reports can only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary.

QE's public reports must include an understandable description of the measures, which include standard quality measures and the rationale for use of alternative measures, risk adjustment methods,

physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors, so that consumers, providers of services and suppliers, health plans, researchers, and other stakeholders can assess such reports. Prior to their public release, these reports must be made available confidentially to any provider of services or supplier to be identified in such report, and provide them with an opportunity to appeal and correct errors. Prior their public release, the QEs must also make the format of the reports available to the Secretary.

Data released to a QE is not subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.

Committee Bill

The Committee Bill would expand the availability of CMS claims data to QEs and the ability of QEs to provide non-public analyses and access to their CMS data combined with their other data. The Committee Bill also would provide qualified clinical data registries with access to the same CMS claims data as QEs.

Beginning July 1, 2014, to the extent consistent with applicable information, privacy, security, and disclosure laws, a QE would, as determined appropriate by the Secretary, be able to use its CMS data combined with its other data to conduct analyses for non-public uses. The QE could provide or sell these non-public analyses to any of the following entities: (1) a provider of services or a supplier, (2) a medical society or hospital association, (3) a health insurance issuer providing claims data to the QE, (4) an employer, as defined under Section 3(5) of the Employee Retirement Insurance Security Act of 1974 (ERISA, P.L. 93-406), but only for the purpose of providing health insurance to its employees and retirees, or (5) other entities approved by the Secretary. However, the Secretary could not grant access to analyses to an employer (under the ERISA) for purposes other than providing health insurance to its employees and retirees or to a health insurance insurer that does not provide claims data to the QE.

QEs would be able to perform these non-public analyses for the following purposes: (1) helping providers develop and participate in quality and patient care improvement activities (including developing new models of care), (2) population health management, (3) disease monitoring, (4) assisting employers with providing health insurance to their employees, and (5) other purposes approved by the Secretary.

A QE analysis for a provider could include information individually identifying the provider's patients but only for services performed by the provider to the identified patients. In all other instances, QE analyses could not include any information that individually identifies a patient. An entity receiving an analysis from a QE could not redisclose or make the analysis public.

If a non-public analysis were to individually identify a provider that is not being provided or sold the analysis, the QE would have to provide the identified provider with an opportunity to review and submit corrections to the analysis.

A QE would also be able to provide or sell access to its CMS data combined with its other data through a qualified data enclave, defined as a web-based portal (or comparable mechanism) that is ca-

pable of providing access to the combined data maintained by the QE. The QE could provide or sell access to the enclave to any of the following entities: (1) a provider of services, (2) a supplier (3) a medical society or hospital association, and (4) other entities approved by the Secretary. However, the Secretary could not grant access to the data through a qualified data enclave to an employer (under the ERISA) or to a health insurance insurer.

These entities would only be permitted to use the data for the purposes of (1) assisting providers in developing and participating in quality and patient care improvement activities (including developing new models of care), (2) population health management, (3) disease monitoring, and (4) other purposes approved by the Secretary.

A data enclave would have to block entities accessing the data enclave from removing or extracting data from the enclave. The enclave would also have to block access to data that individually identifies a patient, including data on the patient's name and date of birth as well as other data specified by the Secretary. The data enclave could grant a provider or supplier with access to identified patient data, but only on services the provider or supplier performs for their patients. QEs cannot grant access to the data enclave to an entity (provider, medical society, etc.) unless the QE and the entity have entered into a data use agreement.

Any QE that would provide or sell non-public analyses or access to a qualified data enclave would have to submit to the Secretary an annual report that includes the following information: (1) a summary of the analyses provided or sold, including the number of analyses, the number of purchasers, and the total amount of fees received for the analyses; (2) a description of the topics and purposes of the analyses; (3) information on the entities who obtained access to the qualified data enclave, the uses of the data, and the total amount of fees received for providing access; and (4) other information determined appropriate by the Secretary.

Beginning July 1, 2014, if the Secretary determines appropriate, the Secretary could provide to QEs standardized extracts (as the Secretary determines appropriate) of claims data under Medicaid and the Children's Health Insurance Program for assistance providing for one or more specified geographic areas and time periods requested by a QE. When issuing the data to QEs, the Secretary must take the appropriate actions needed to protect the identity of individuals entitled to or enrolled for these programs' benefits.

Beginning on July 1, 2014, QE fees paid to the Secretary for providing data extracts would be deposited in the CMS Program Management Account instead of the Federal SMI Trust Fund.

To the extent consistent with applicable information, privacy, security, and disclosure laws, and subject to other requirements as the Secretary may specify, beginning July 1, 2014, qualified clinical data registries would be able to purchase the same CMS claims data (in a form and manner determined appropriate by the Secretary) as QEs in order to link the data with clinical data and perform analyses and research to support quality improvement or patient safety.

Effective July 1, 2014, if the Secretary determines appropriate, the Secretary may make available to qualified clinical data registries standardized extracts under Medicaid and the Children's

Health Insurance Program. Any fees the Secretary was to collect by making such data available would be deposited in the CMS Program Management Account.

A qualified clinical data registry could not publicly report any research, analyses, or CMS data that individually identifies a provider, supplier or individual unless the registry was to obtain the consent of the provider, supplier or individual prior to reporting.

TITLE II—EXTENSIONS AND OTHER PROVISIONS

Subtitle A—Medicare Extensions

SEC. 201. WORK GEOGRAPHIC ADJUSTMENT

Present Law

The Medicare physician fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to provide physician services: physician work, practice expense, and medical malpractice insurance. These geographic adjustments are an index—known as Geographic Practice Cost Index (GPCI)—that reflect how each area compares to the national average. A value of 1.00 represents the average across all areas. This index is used in the calculation of the payment rate under the Medicare physician fee schedule. A series of bills set a temporary floor value of 1.00 on the physician work GPCI beginning January 2004 and continuing through December 31, 2013.

Committee Bill

The floor on the work geographic index would be set permanently at 1.0.

SEC. 202. MEDICARE PAYMENT FOR THERAPY SERVICES

Present Law

The BBA established two annual per beneficiary payment caps for all Medicare-covered outpatient therapy services furnished by non-hospital providers, one for physical therapy services and speech-language pathology services, the other for occupational therapy services. Initially set at \$1,500 to apply beginning in 1999, these caps were suspended from 2000–2005. With the application of the caps beginning in 2006, the DRA required the Secretary to implement an exceptions process throughout 2006 for services meeting specified criteria for medically necessary services. Subsequent legislation has extended the exceptions process and increased the caps each year since then.

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA, P.L. 112–96) established, in addition to the caps, an annual threshold at \$3,700 to be applied separately for the two categories of therapy services effective October 1, 2012. Medical review was required for services furnished above the threshold. In addition, therapy services furnished in HOPDs were included in the caps for the first time. The ATRA extended the exceptions process through December 31, 2013, extended the application of the cap and threshold to therapy services furnished in a HOPD and requires outpatient therapy services furnished in a Critical Access Hospital (CAH) to count towards the cap and threshold. The ATRA

also extended the medical review requirement for therapy services furnished through December 31, 2013.

MCTRJCA also directed the Secretary, in consultation with relevant stakeholders, to implement a claims-based data strategy designed to collect data on patient function during the course of outpatient therapy services beginning January 1, 2013. The data will assist in reforming the Medicare payment system for outpatient therapy services.

Committee Bill

The therapy cap would be repealed upon enactment. The \$3,700 threshold would be extended for one year, through the end of 2014, after which it would be repealed. Beginning January 1, 2015, a new medical review program for outpatient therapy services would be established as defined below. The Secretary would identify the services for medical review, using appropriate factors, which could include the following:

(a) Services furnished by a therapy provider whose pattern of billing is higher compared to peers.

(b) Services furnished by a therapy provider who, in a prior period, has a high claims denial percentage or is least compliant with other applicable requirements under this title.

(c) Services furnished by a therapy provider who is newly enrolled in the Medicare program.

(d) Services furnished by a therapy provider who has questionable billing practices, such as billing medically unlikely units of services in a day.

(e) Services furnished to treat a type of medical condition.

(f) Services identified by use of the standardized data elements required to be reported.

(g) Services furnished by a single therapy provider or a group that includes such providers.

(h) Other services as determined appropriate by the Secretary.

The Secretary would use prior authorization medical review for the identified outpatient therapy services furnished to a beneficiary above certain thresholds established by the Secretary, such as a dollar threshold or by type of outpatient therapy service or setting.

The Secretary would end the application of prior authorization medical review if the provider has a low denial rate under prior authorization. The Secretary could subsequently reapply prior authorization medical review to the therapy provider if this were determined to be appropriate. The Secretary would, where practicable, provide for prior authorization medical review for multiple services at a single time, such as services in a therapy plan of care.

The Secretary could use pre-payment review or post-payment review for services that are not subject to prior authorization medical review, including those services falling below the established thresholds. So as to not interfere with an ongoing investigation, the Secretary could determine that medical review does not apply in the case where fraud may be involved. The Secretary would conduct the prior authorization medical review of outpatient therapy services using Medicare administrative contractors (MACs) or other review contractors.

No Medicare payment would be made for outpatient therapy services subject to this review unless a prior authorization deter-

mination were made in advance that the services met the Medicare reasonable and necessary requirements. A therapy provider could submit the information necessary for medical review by fax, by mail, or by electronic means. As soon as practicable, but not later than 24 months after the date of enactment, the Secretary would have to make available the electronic means necessary to receive information.

The Secretary would make a prior authorization determination within ten business days of receipt of the necessary medical documentation or be deemed to have found the services to meet the applicable requirements for Medicare coverage. The Committee Bill would not preclude subsequent payment denial for an outpatient therapy service that had been affirmed by medical review but did not meet other applicable Medicare requirements.

For outpatient therapy services furnished on or after January 1, 2015, when payment may not be made due to medical review, the current law limiting beneficiary liability when Medicare claims are disallowed would apply in the same manner as a claims denial when a service is not reasonable and necessary.

The Secretary could implement this medical review program by interim final rule with comment period. Requirements under current law (44 U.S.C. §§ 3501–3521) regarding coordination of federal information under the Paperwork Reduction Act would not apply to this medical review program.

For purposes of this subsection the following definitions would apply. The term ‘outpatient therapy services’ would mean therapy services for which Medicare payment is made under the physician fee schedule, under the fee schedule for outpatient therapy services and comprehensive outpatient rehabilitation services, and under the payment system for outpatient CAH services. The term ‘therapy provider’ would mean a provider of services (as defined under current law section 1861(u) of the SSA) or a supplier (as defined under current law section 1861(d)) who furnishes outpatient therapy services.

To implement this subsection, the Secretary would provide for the transfer of \$35,000,000 from the SMI Trust Fund to the CMS Program Management Account for each fiscal year, beginning with fiscal year 2014. These amounts would remain available until expended.

Beginning with 2017 and then every two years, the Secretary would have to determine and publicly report the improper payment rate for outpatient therapy services for a 12-month period. If the improper payment rate is 50 percent or less of the Medicare FFS improper payment rate for the same period, the Secretary would have to reduce the amount of medical review conducted for a prospective year and return an appropriate portion of the funding provided for that year.

The GAO would conduct a study on the effectiveness of medical review of outpatient therapy. The study would include an analysis of aggregate data on the number of individuals, therapy providers, and claims subject to review; the number of reviews conducted; and the outcomes of such reviews. Not later than three years after the date of enactment, the GAO would submit a report to Congress including recommendations for legislation and administrative action.

The Committee Bill would establish the collection of standardized data elements for outpatient therapy services. Not later than six months after enactment, the Secretary would post a draft list of standardized data elements on the CMS website. The standardized data elements would include information with respect to the following domains, as determined appropriate by the Secretary: (1) demographic information, (2) diagnosis, (3) severity, (4) affected body structures and functions, (5) limitations with activities of daily living and participation, (6) functional status, and (7) other domains determined appropriate by the Secretary.

The Secretary would accept comments from stakeholders for 60 days after the posting date of the draft standardized data elements. In seeking such comments, the Secretary would use one or more mechanisms to solicit input from stakeholders that could include use of open door forums, town hall meetings, requests for information, or other mechanisms as determined appropriate by the Secretary.

No later than 120 days after the end of the comment period, the Secretary would post an operational list of standardized data elements on the CMS website, taking into account such comments. Subsequent revisions to the operational list of standardized data elements would be made through rulemaking and could be based on experience and input from stakeholders. No later than 18 months after posting the operational list of standardized data elements, the Secretary would develop and implement a system, which may be a web portal, for therapy providers to report the standardized data elements for individuals receiving outpatient therapy services. The Secretary would seek comments from stakeholders regarding the best way to report the standardized data elements.

The Secretary would specify the frequency of reporting standardized data elements and seek comments from stakeholders regarding the frequency of the reporting. Beginning on the operational date of the reporting system, no Medicare payment would be made for outpatient therapy services furnished to a beneficiary unless a therapy provider were to report the standardized data elements for the beneficiary.

No later than 18 months after the date the data reporting system is operational, the Secretary would submit a report to Congress on the design of a new payment system for outpatient therapy services. The report would include an analysis of the standardized data elements collected and other appropriate data and information. It would consider (1) appropriate adjustments to payment (such as case mix and outliers), (2) payments on an episode of care basis, and (3) reduced payment for multiple episodes. The Secretary would consult with stakeholders regarding design of such a new payment system.

To implement the data collection effort and develop the report on a new outpatient therapy payment system, the Secretary would provide for the transfer of \$7,000,000 from the SMI Trust Fund to the CMS Program Management Account for each fiscal year from 2014 through 2018. The amounts transferred would remain available until expended.

Requirements under current law (44 U.S.C. §§3501–3521) regarding coordination of federal information, including the Paper-

work Reduction Act, would not apply to the specification of the standardized data elements and implementation of the reporting system. There would be no administrative or judicial review of the specification of standardized data elements required under this subsection or the reporting system. For purposes of the specification of standardized data elements and the implementation of the reporting system, the terms ‘outpatient therapy services’ and ‘therapy provider’ have the meaning given those terms for the new medical review program.

The current claims-based data collection strategy designed to assist in reforming the Medicare payment system for outpatient therapy services, which was mandated by the MCTRJCA, would sunset effective the date of implementation of the data collection effort established above.

The Committee Bill would require that each request for payment, or bill submitted on or after January 1, 2015, by a therapy provider for an outpatient therapy service furnished by a therapy assistant include an indication that the service was furnished by a therapy assistant (in a form and manner specified by the Secretary).

SEC. 203. MEDICARE AMBULANCE SERVICES

Present Law

The Medicare Prescription Drug, Improvement and Modernization Act (MMA, P.L. 108–173) established temporary bonus payments for ground ambulance services that originate in a qualified rural area furnished on or after July 1, 2004 and before January 1, 2010. Qualified rural (also referred to as “super rural”) areas are those where the ambulance transport originates in a rural area determined by the Secretary to be in the lowest 25th percentile in terms of population density of all rural county populations. The bonus payment is a 22.6 percent increase. Subsequent legislation has extended the bonus payments for super rural ambulance services until December 31, 2013.

The MMA also provided temporary increases to ground ambulance services that originate in rural and urban areas. The MIPPA extended the ground ambulance add-on policy in July 2008 after a short lapse. The MIPPA also increased the level of the add-on payment from one percent to two percent for urban ambulance services and from two percent to three percent for rural ambulance services. Subsequent legislation has extended the temporary add-on payments until December 31, 2013.

Committee Bill

The Committee Bill would extend all of the current temporary ambulance payments an additional five years for services furnished before January 1, 2019.

Additionally, the Committee Bill would require the Secretary to develop a data collection system for ambulance providers and suppliers in consultation with stakeholders. The data collection system for ambulance services would include cost, revenue, utilization, and other information to evaluate appropriate payment rates, the utilization of capital equipment and ambulance capacity, and the different types of ambulance services furnished in different geographic regions. No later than January 1, 2015, the Secretary

would be required to specify the data collection methodology and to identify a sample of providers and suppliers required to submit such data. Beginning July 1, 2015, identified providers and suppliers who fail to submit such data would receive a five percent reduction in Medicare ambulance payments for a one-year period.

Under the Committee Bill, the Secretary would be permitted to revise the data collection system as appropriate, after consultation with providers and suppliers of ambulance services. Such consultation would include the use of requests for information and other appropriate mechanisms. In order to continue to evaluate the appropriateness of payment rates, ambulance providers and suppliers would be required to submit such information no less than once every three years. Requirements under current law (44 U.S.C. §§ 3501–3521) regarding coordination of federal information, including the Paperwork Reduction Act, would not apply to the collection of this information. There would be no administrative or judicial review of the data collection system or those identified as required to submit such information.

For purposes of developing this data collection system, the Secretary would provide for the transfer of \$1 million from the SMI Trust Fund to the CMS Program Management Account for fiscal year 2014.

SEC. 204. MEDICARE DEPENDENT HOSPITALS

Present Law

The Omnibus Budget Reconciliation Act of 1989 (OBRA89, P.L. 101–239) created a new Medicare Dependent Hospitals (MDHs) program that made small, rural hospitals eligible for additional payments. The MDH program lapsed in 1994 but was reinstated by the BBA. The program has been extended periodically and changed by subsequent legislation. The MDH special payment status expired on September 30, 2013.

MDHs are small rural hospitals with a high proportion of patients who are Medicare beneficiaries. MDHs have no more than 100 beds and at least 60 percent of acute inpatient days or discharges attributable to Medicare in FY1987 or in two of the three most recently audited cost reporting periods. Specifically, an MDH hospital will be paid the inpatient prospective payment system (IPPS) rate plus a percentage difference between that amount and a hospital-specific cost per discharge amount from a given year. Before October 1, 2006 an MDH received 50% of the difference between the base rate and its adjusted hospital-specific costs. Since October 1, 2006, a MDH has received 75% of the difference between the base rate and its adjusted hospital-specific costs.

Committee Bill

The Committee Bill would make the MDH program permanent.

SEC. 205. LOW VOLUME HOSPITALS

Present Law

Under the Medicare IPPS, certain low-volume hospitals receive a higher payment amount to account for their higher costs per discharge in 2012 and 2013. The adjustment operates on a sliding scale with hospitals having fewer than 200 Medicare discharges re-

ceiving a 25% payment increase, decreasing on a sliding scale to 0% for hospitals with more than 1,600 Medicare discharges. These hospitals must be located 15 miles or more from another comparable hospital. This adjustment expired on September 30, 2013.

The low-volume adjustment is based on the concept that large hospitals benefit from certain economies of scale that are not available to small hospitals with limited discharges. MedPAC has reported that this adjustment is not well targeted because hospitals may have a small number of Medicare patients while also treating a large number of non-Medicare patients. In MedPAC's view, Congress may wish to consider changing the low volume formula to reflect total discharges rather than Medicare discharges.

Committee Bill

The Committee Bill would make the low-volume hospital policy permanent.

SEC. 206. MEDICARE SPECIAL NEEDS PLANS

Present Law

Section 231 of the MMA established a new type of MA coordinated care plan to focus on individuals with special needs. SNPs are allowed to target enrollment to one or more types of special needs individuals including (1) institutionalized (I-SNPs), (2) dually eligible (D-SNPs), and/or (3) individuals with severe or disabling chronic conditions (C-SNPs). Fully Integrated Dual Eligible SNPs (FIDE-SNPs) are a subset of D-SNPs that must fully integrate Medicare and Medicaid benefits, including long-term care services and supports, and have a contract with the state Medicaid program among other requirements.

In general, SNPs are required to meet all applicable statutory and regulatory requirements that apply to MA plans, including: state licensure as a risk-bearing entity; MA reporting requirements that are applicable depending on plan size; and Part D prescription drug benefit requirements. SNP payment procedures mirror CMS's procedures for MA plans. SNPs prepare and submit a bid like other MA plans, and are paid in the same manner as other MA plans based on the plan's enrollment and risk adjustment payment methodology.

Among other changes, the MIPPA required that all SNPs have evidenced-based models of care (MOC). An MA organization must design separate MOCs to meet the special needs of the target population for each SNP it offers. MOCs must have goals and objectives for the targeted population, a specialized provider network, use nationally-recognized clinical practice guidelines, conduct health risk assessments to identify the special needs of beneficiaries, and add services for the most vulnerable beneficiaries including, but not limited to those beneficiaries who are frail, disabled, or near the end-of-life.

The ACA extended SNP authority through December 31, 2013 and temporarily extended authority through the end of 2012 for SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service areas. Other ACA changes applicable to SNPs included the following: (1) required all SNPs to comply with an approval process that will be

based on CMS standards and executed by the National Committee for Quality Assurance (NCQA) beginning January 1, 2012. NCQA rating is based on scores for each of eleven clinical and non-clinical elements in each SNPs MOC; (2) authorized CMS to pay a frailty adjustment payment to FIDE-SNPs; (3) established new cost-sharing requirements for SNPs; and (4) required CMS to implement new quality-based payment procedures for all MA plans by 2012.

In addition, the ACA required the Secretary to establish the Federal Office of Coordinated Health Care (MMCO) within CMS to facilitate Medicare and Medicaid coordination for dually eligible beneficiaries.

The ATRA extended SNP authority through December 31, 2014, and also temporarily extended authority for SNPs that do not have contracts with state Medicaid programs to continue to operate, but not to expand their service areas. Beginning January 1, 2015, SNP enrollment will not be restricted only to special needs individuals.

Committee Bill

The Committee Bill would permanently authorize I-SNPs, re-authorize D-SNPs through December 31, 2020, and re-authorize C-SNPs through December 31, 2017.

The Committee Bill would require the Secretary to establish by, April 1, 2015, procedures that would unify the Medicare and Medicaid appeals procedures applicable to D-SNPs. In establishing unified Medicare-Medicaid appeals procedures, the Secretary would be required to solicit comments from states, plans, beneficiary representatives, and other relevant stakeholders. To the extent compatible with the process for unifying Medicare and Medicaid appeals procedures, the Secretary would ensure that the following requirements were included: (1) adoption of the most protective provisions for D-SNP enrollees under current law, including continuation of benefits under Medicaid pending timely filed appeals; (2) differences in Medicaid state plans are taken into account; and (3) be easily navigable by D-SNP enrollees.

The unified procedures must also include: (1) a single notification of all applicable Medicare and Medicaid appeal rights; (2) appeals notices written in plain language and available in a language and format that is accessible to enrollees; (3) unified Medicare and Medicaid timeframes for internal (plan) and external (Medicare and Medicaid) appeals, such as the enrollee's filing of appeals, plan acknowledgement, and appeal resolution and notification of appeal decisions; and (4) mechanisms to allow D-SNP plans to track and resolve grievances. The Committee Bill would require that, beginning January 1, 2016, D-SNP plan contracts use the unified Medicare-Medicaid appeals procedures.

The Committee Bill would require that, beginning January 1, 2018, most D-SNPs would be required to integrate all Medicare and Medicaid benefits and meet the requirements for a FIDE-SNP, including, to the extent current state law under the state's Medicaid plan permitted capitated payments for long-term care services or behavioral health services. However, for purposes of the integration requirements beginning in 2018, the definition of a FIDE-SNP does not include the requirement that the D-SNP's enrollment have similar average levels of frailty as the Programs of All-Inclusive Care for the Elderly (PACE) program. If the Secretary deter-

mines that D-SNPs failed to meet contract requirements for full integration of all Medicare and Medicaid benefits for 2018 or 2019, the Secretary is authorized to impose one of the following sanctions: (1) reduce MA payments; (2) close enrollment to new plan enrollees; (3) apply MA sanctions, including civil money penalties and suspension; and (4) other reasonable actions as determined by the Secretary (except deeming that the plan no longer meets the definition of a D-SNP). Finally, the Committee Bill requires that in order to meet the definition of a D-SNP for 2020 and subsequent years, D-SNPs must fully integrate Medicare and Medicaid benefits and meet the current law definition of a FIDE-SNP.

D-SNPs that only enroll Medicare beneficiaries for whom the only Medicaid benefit to which the individuals are entitled is Medicare cost-sharing assistance would not be required to fully integrate Medicare and Medicaid benefits in their contracts effective January 1, 2018.

The Committee Bill would designate the MMCO as the dedicated CMS contact to assist states in addressing D-SNP Medicare-Medicaid misalignments. In this role, MMCO would be required to establish a uniform process for disseminating Medicare contract information to state Medicaid agencies as well as to D-SNPs. MMCO would also be required to establish basic resources for states that are interested in exploring D-SNPs as a platform for integrating Medicare-Medicaid services for dual eligible beneficiaries.

The Committee Bill would add the following requirements for C-SNP care management plans beginning with contracts effective January 1, 2016: (1) the interdisciplinary provider team that C-SNPs are required to have would include providers with training in an applicable specialty and demonstrated expertise in treating individuals with the chronic conditions the C-SNP would target; (2) requirements developed by the Secretary to provide face-to-face encounters with the C-SNP's enrollees; (3) a requirement that MOC include the results of the initial assessment and each annual reassessment are addressed in the enrollee's required individualized care plan; (4) the Secretary would be required to ensure that as part of the annual MOC evaluation that whether or not the plan fulfilled the goals identified would be taken into account; and (5) the Secretary would be required to establish a minimum benchmark for each MOC element and to only approve a C-SNP's MOC if each element met those minimum benchmarks.

The Committee Bill would make changes to the SNP quality ratings and measurement and publication. Beginning with contracts effective January 1, 2016, the Secretary would be required to increase emphasis on SNPs' performance improvement or decline when determining a plan's annual star ratings. Specifically, the Secretary would be required to ensure that at least 25 percent but not more than 33 percent of the annual star rating is based on the SNP's performance improvement or decline. The Secretary would be required to measure the SNP performance improvement or decline based on the net change in the SNP plan's individual star rating measures. In order to ensure that plans are not punished in cases where it is impossible to improve, the Secretary would be authorized to appropriately adjust SNP plan improvement ratings when plans have achieved a 5-Star rating or the highest overall rating possible for individual measures. This increased emphasis

on improvement would not apply to SNPs with an overall star rating of not more than 2.5 stars.

The Committee Bill would allow the Secretary to report and apply quality ratings of SNPs at the plan level instead of the contract level, as it is under current law. In requiring reporting and applying quality ratings at the plan level, the Secretary would be required to take into consideration the minimum enrollment that would be necessary to enable valid quality measurement at the plan level. In the instance the Secretary reports quality measures at the plan level, the quality measurement must include the Medicare Health Outcomes Survey, Healthcare Effectiveness Data Information Set, and Consumer Assessment of Healthcare Providers and Systems measures. Also, if the Secretary uses the option to require quality reporting and the application of ratings at the plan level, then payment and other administrative actions linked to qualify measurement would be applied at the plan level.

The Committee Bill would require that GAO conduct a study to determine how the Secretary could change the MA SNP quality measurement system to allow an accurate comparison of the care quality provided by SNPs for individual plans as well as for SNPs overall, to the care quality delivered under Medicare FFS and other MA plans for similar populations. GAO would be required to submit the report on SNP quality compared to other Medicare delivery sources by July 1, 2016. GAO's report would be required to contain recommendations for legislative and administrative action as determined appropriate by GAO.

SEC. 207. MEDICARE COST CONTRACTS

Present Law

Medicare cost contracts are contracts with private health plans where plan payment is based on the reasonable costs actually incurred to provide Medicare covered benefits to enrollees. Cost contracts were first authorized by the Social Security Amendments of 1972 (P.L. 92-603), as were contracts that paid private health plans a modified per capita (risk-based) monthly payment. The BBA prohibited the Secretary from extending or renewing cost contracts beyond December 31, 2002, while also transitioning the risk-based contracts to the new Medicare+Choice program, later to become the MA program. Seven subsequent pieces of legislation extended the Secretary's authority to enter into cost contracts, as follows:

(1) The Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) extended the authority through 2004.

(2) The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) allowed cost contracts to expand their service areas if the request was submitted to the Secretary before September 1, 2003.

(3) The MMA allowed cost contracts to be extended or renewed indefinitely. However, beginning in 2008, these contracts could not be extended or renewed for a service area that during the previous year had two or more MA regional plans or two or more MA local (formerly Medicare+Choice) plans.

(4) The Medicare, Medicaid, and SCHIP Extensions Act of 2007 (MMSEA, P.L. 110-173) extended by one year—from January 1,

2008, to January 1, 2009—the length of time a cost plan could continue to operate in an area previously served by two or more local MA plans or two or more regional MA plans.

(5) The MIPPA extended by one year—from January 1, 2009, to January 1, 2010—the length of time a cost plan could continue to operate in an area previously served by two or more local or two or more regional plans. To prohibit a cost plan from participating after January 1, 2010, the two or more plans in the service area were required to be offered by different organizations, and meet minimum enrollment requirements.

(6) The ACA extended by three years—from January 1, 2010 to January 1, 2013—the length of time a cost plan could continue to operate in an area previously served by two or more local or two or more regional plans that met minimum enrollment requirements.

(7) The ATRA extended by one year—from January 1, 2013 to January 1, 2014—the length of time a cost plan can continue to operate in an area previously served by two or more local or two or more regional plans that meet minimum enrollment requirements.

Under current law, Medicare cost contracts can be extended or renewed indefinitely, except that, under current authority, beginning on or after January 1, 2014, these contracts may not be extended or renewed in areas that during the entire previous year (2013) had two or more MA regional plans or two or more MA local plans offered by different organizations, with a minimum enrollment. These cost contracts will not be renewed at the end of 2014, based on minimum enrollment data for the 2013 contract year, and will cease to operate after 2014.

Committee Bill

Effective for plan year 2015, the Committee Bill would allow the Secretary to extend or renew cost contracts that had served an area where two or more local or regional MA plans with minimum enrollment had served in 2013, but would prohibit new enrollment into those cost contract plans for 2015.

Cost contract plans with restricted enrollment in 2015 would be able to apply to convert to a new (MA) plan under Part C in 2016 (if they were to notify the Secretary of their intent to do so by a date specified by the Secretary), or have their contract terminated effective 2016.

The Secretary would be required to establish a process whereby the enrollees of the cost contract plans that were to convert to MA plans for 2016 would be automatically enrolled into a new MA plan. The automatic enrollment into the newly converted MA plans would also apply to the cost plan's enrollees with End Stage Renal Disease. Cost plans that included a drug benefit would be required to retain drug coverage as part of their new MA plan. Similarly, cost plans that did not include a drug benefit would not be allowed to add one when applying to convert to MA plans. The MA monthly beneficiary premium for a converted plan would not be allowed to exceed the monthly premium under the previous cost contract by more than ten percent. The converted plan would be required to provide benefits, premiums, and access to providers comparable to what was available under the cost plan the previous year. To ensure continuity of care, the converted MA plan would be required

to maintain current providers and courses of treatment for enrollees at the time of enrollment for at least 90 days after enrollment. During this 90-day period, the converted plan would be required to pay non-contracted providers for items and services furnished to enrollees at amounts not less than amounts paid under original FFS Medicare.

The Secretary would be required to identify the affected enrollees of plan conversions by no later than 30 days prior to the start of the annual coordinated election period (which begins on October 15th). Enrollees subject to the automatic enrollment would be able to change their enrollment during the annual, coordinated election period to a different MA plan or to Medicare fee-for-service and could also change their enrollment one additional time during a period starting after the last day of the annual, coordinated election period (December 7th) and ending on the last day of February of the following year.

Prior to the start of the annual coordinated election period, the Secretary would be required to send affected enrollees a notification of their automatic enrollment into the new MA plan and information about their options to make a different election during the annual coordinated election period and/or their additional special election period. The Secretary would also be required to provide affected enrollees with a description of the differences in benefits, cost-sharing, premiums, drug coverage, and provider networks between their former cost plan and the new MA plan.

The Secretary would be required to adjust the star quality rating used to set the maximum payment rate for MA plans so that the star rating for the newly converted MA plan for its first two plan years would be equal to the star rating assigned to the cost plan in the last year before it was converted to a new MA plan.

SEC. 208. QUALITY MEASURE ENDORSEMENT AND SELECTION

Present Law

As required by section 1890 of the SSA, the Secretary identifies and contracts with a consensus-based entity, such as the National Quality Forum, that makes recommendations on an integrated national strategy and priorities for health care performance measurement. The entity is required to carry out specified duties related to performance improvement and measurement. These duties include, among others, priority setting; measure endorsement; measure maintenance; convening multi-stakeholder groups to provide input on the selection of quality measures and national priorities; and annual reporting to Congress. The MIPPA (which added section 1890 of the SSA) appropriated \$10 million for each of the FY2009 through FY2012; subsequent legislation extended this funding through FY2013.

Under current law, the Secretary is required to establish a pre-rulemaking process to select quality measures for use by Medicare. This process includes gathering multi-stakeholder input; making measures under consideration available to the public; transmission to, and consideration by, the Secretary of the input of multi-stakeholder groups; and the publication of the rationale for the use of any quality measure in the Federal Register; among others. The Secretary is also required to establish a process for disseminating

quality measures used and to periodically review quality measures and determine whether to maintain the use of a measure or to phase it out.

Committee Bill

Generally, the Committee Bill would modify the duties for the consensus-based entity, create a new entity to carry out duties related to the selection of quality measures, and modify the duties for the Secretary in a new section of the SSA. The changes under this section would be effective as of October 1, 2014, and would apply to contract periods that begin on or after October 1, 2014. Specifically, the Committee Bill would re-designate existing SSA section 1890A as section 1890B, and would add a new section 1890A titled “Contract with an Entity Regarding Input on the Selection of Measures.”

The Committee Bill creates a new entity to carry out duties related to the selection of quality measures in order to allow more entities to bid for the contract and enhance the competitiveness of the process. The new entity must meet a number of requirements to qualify for becoming the measure selection entity. Specifically, an entity must meet the following requirements to qualify for becoming the new entity under section 1890A: (1) be a private non-profit entity; (2) be governed by a board including representatives of health plans, health care providers and practitioners, health care consumers, purchasers, and employers; (3) have at least four years of experience working with measures; (4) have no membership fees or fees that are reasonable and adjusted based on the capacity of a potential member to pay. Membership fees would not be allowed to pose a barrier to the participation of individuals or groups with low or nominal resources in the entity’s functions; and (5) not be a measure developer.

The Committee Bill would transfer to the measure selection entity the following duties currently under the consensus-based entity: (1) priority setting, (2) the convening of multi-stakeholder groups, and (3) the transmission of multi-stakeholder input. The Committee Bill would also create additional duties for the new measure selection entity. The entity would facilitate increased coordination and alignment between the public and private sectors with respect to quality and efficiency measures. The entity would have to conduct an ongoing analysis of gaps in endorsed quality and efficiency measures. By March 1st of each year, the new entity would have to issue a report on (1) the performance of its duties, (2) the recommendations of the entity’s priority setting process, (3) the multi-stakeholder groups’ input on the selection of quality and efficiency measures, (4) the findings of its gap analysis, and (5) any other items determined appropriate by the Secretary. The contract must be awarded beginning in FY2015; continue for a period of three years; and adhere to competitive bidding procedures.

The Committee Bill would require the Secretary to provide for the transfer of \$7 million for FY2014, from the Hospital Insurance (HI) and SMI Trust Funds to the CMS Program Management Account, to carry out the activities in existing section 1890 and section 1890A(a)-(d). These amounts would remain available until expended. The Committee Bill would also require the Secretary to provide for the transfer of \$25 million for each of fiscal years 2015

through 2017, from the HI and SMI Trust Funds to the CMS Program Management Account, to carry out section 1890; section 1890A; and section 1890B (excluding sections 1890B(e) and (f)).

While acknowledging that it can be difficult to recruit all appropriate stakeholders, the measure selection entity, to the extent feasible, would make every effort to ensure its multi-stakeholders groups are balanced across stakeholders. The Committee Bill would also require the multi-stakeholder groups' input to include a detailed description of the rationale for each recommendation made. Such rationales could include (1) the expected impact of the measure on individuals, (2) the burden on providers and suppliers, (3) the expected influence over the behavior of providers and suppliers, (4) applicability of a measure for more than one setting or program, and (5) other areas determined in consultation with the Secretary. In providing the input, the entity could consider whether it is appropriate to provide separate recommendations with respect to measures for the internal use of a provider or supplier, quality reporting, public reporting, and payment provisions. The Committee Bill would also direct the multi-stakeholder group to provide input on the selection of quality and efficiency measures for use in other SSA health care programs other than Medicare.

In order to make the contracting process more competitive, the Committee Bill would modify the process for the consensus-based entity, requiring the Secretary to rebid the contract for the entity at least every three years, instead of every four years. It would strike the statutory reference to the National Quality Forum as an example of a possible consensus-based entity. In order to avoid potential conflicts of interest, it would also require that the entity not be a measure developer.

The Committee Bill would strike the existing requirement that the consensus based entity review and endorse episode groupers. The consensus based entity would also facilitate increased coordination and alignment between the public and private sector with respect to quality and efficiency measures.

In order to provide flexibility and facilitate management of the measures workload, the Committee Bill would require the Secretary to make its list of measures available to the public and the measure selection entity for pre-rulemaking input by no later than October 1st or December 31st of each year. The Committee Bill directs the Secretary to provide for an appropriate balance of the number of measures to be made available by each of the two dates in a year. This change would space out the measure selection entity's receipt of measures and ensure that the entity has enough time to review the measures. For measures received on October 1st, the entity would have to transmit the input by February 1st. For measures received on December 31st, the entity would have to transmit the input by April 1st. However, the Secretary could make available to the public a limited number of measures apart from the dates above. In turn, the entity with a contract under section 1890A would transmit to the Secretary the multi-stakeholder group's input on a timely basis.

The Committee Bill would also require the Secretary to consider the benefits of the alignment of measures between the public and private sector when periodically reviewing quality and efficiency measures.

The Secretary would also be required to publish a list of concordance rates for each type of provider or supplier. Each annual final rule would contain the concordance rate for the applicable type or types of providers and suppliers. The Secretary would also have to publish in the Federal Register the rationale for the use of any quality and efficiency measure that has not been recommended by the multi-stakeholder group.

SEC. 209. OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS

Present Law

Section 119 of the MIPPA appropriated \$25 million for FY2008 and FY2009 for low-income Medicare beneficiary outreach and education activities through the following programs: State Health Insurance Counseling and Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the Administration on Aging (AoA). Section 3306 of the ACA extended authority for the low-income outreach activities and appropriated \$45 million for these programs. The appropriations authorized by the ACA were available for obligation through FY2012. Section 610 of the ATRA extended these appropriations through FY2013 and appropriated the following amounts for low-income Medicare beneficiary outreach and assistance activities: SHIPs, \$7.5 million; AAAs, \$7.5 million; ADRCs, \$5 million; and the Contract with the National Center for Benefits and Outreach Enrollment, \$5 million.

Outreach activities include counseling, education, enrollment assistance, health promotion, and other activities to help low-income Medicare beneficiaries understand their health insurance choices so they can make informed decisions. In addition to providing Medicare beneficiaries with counseling and education about their health insurance choices, outreach activities are intended to help low-income Medicare beneficiaries enroll in the Medicare Savings Program (MSP). MSP helps pay Medicare premiums and cost-sharing for beneficiaries who, due to their low income and assets, are eligible for both Medicare and Medicaid. MSP enrollment historically has been low, so outreach activities have been used to identify individuals who qualify for assistance.

Committee Bill

The Committee Bill would permanently appropriate current level funding (\$25 million each fiscal year) for low-income outreach and assistance activities. These funds would be allocated to the following programs in the same amounts as they are under current law: SHIPs, \$7.5 million; AAAs, \$7.5 million; ADRCs, \$5 million; and the Contract with the National Center for Benefits and Outreach Enrollment, \$5 million.

Subtitle B—Medicaid and Other Extensions

SEC. 211. QUALIFYING INDIVIDUAL PROGRAM

Present Law

The Qualifying Individual (QI) program requires states, through their Medicaid programs, to pay Medicare Part B premiums for Medicare beneficiaries with incomes between 120 and 135 percent

of the Federal Poverty Limit (FPL). Medicaid payment for the QI program is transferred annually from the SMI Trust Fund to the Treasury account that funds medical assistance payments to states and the District of Columbia. Congress appropriates annual funding amounts for all states and CMS allocates the funding to state Medicaid programs. States receive 100 percent federal funding to pay program participant's Medicare Part B premiums up to the maximum number of beneficiaries whose Part B premiums can be paid from their federal allocation, but no additional matching beyond this annual allocation is available. The QI program has been reauthorized and funded a number of times since it was originally authorized. In December 2012, there were approximately 480,300 low-income Medicare beneficiaries who received financial assistance from state Medicaid programs to pay their Part B premiums.

Committee Bill

The Committee Bill would amend the SSA to authorize and fund the QI program by annually transferring funds from the SMI Trust Fund to the Treasury account that funds medical assistance payments to states and the District of Columbia for calendar years 2014 through 2018. The Committee Bill also would remove restrictions on the number of beneficiaries who may receive QI assistance due to the capped allocation that states were required to use in determining which eligible beneficiaries would receive assistance.

SEC. 212. TRANSITIONAL MEDICAL ASSISTANCE

Present Law

Federal law requires states to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income under section 1902(e), of the SSA. This continuation of benefits is known as transitional medical assistance (TMA). Federal law permanently requires states to provide four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections. Federal law also permanently requires four months of TMA for families who lose Medicaid eligibility due to an increase in earned income or hours of employment. Congress expanded work-related TMA benefits under section 1925 of the SSA as part of the Family Support Act of 1988 (FSA, P.L. 100-485), requiring states to provide at least six, and up to 12, months of TMA coverage to families losing Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard. FSA originally authorized section 1925 of the SSA to replace the four-month requirement in section 1902(e)(1) of the SSA through FY1998. However, the provision has continued to exist under a series of extensions since its inception.

Committee Bill

The Committee Bill would extend section 1925 TMA through December 31, 2018. The Committee Bill would also permit states and the District of Columbia that: (1) take up the ACA Medicaid expansion and (2) take up a new continuous eligibility option to seek CMS approval to opt out of sections 1902(e) and 1925 TMA-related

requirements. Such an opt out would not violate the ACA child maintenance of effort provision which requires states to maintain their Medicaid programs with the same eligibility standards, methodologies and procedures for children up to age 19 until September 30, 2019.

The Committee Bill also modifies the TMA-related requirements under Medicaid and Temporary Assistance for Needy Families (TANF) to consider only increases in income due to spousal support collections as a trigger for TMA eligibility. This change would conform the income counting rules for TMA to the new Modified Adjusted Gross Income counting rules that will be used to determine Medicaid income eligibility for most Medicaid-eligible populations beginning January 1, 2014.

SEC. 213. EXPRESS LANE ELIGIBILITY

Present Law

The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111–3) created a state plan option for “Express Lane” eligibility whereby states are permitted to rely on a finding from specified “Express Lane” agencies (e.g., those that administer programs such as TANF, Medicaid, CHIP, and Supplemental Nutrition Assistance Program) for: (1) determinations of whether a child has met one or more of the eligibility requirements necessary to determine his or her initial eligibility or (2) eligibility redeterminations. Authority for “Express Lane” eligibility determinations will sunset on September 30, 2014.

Committee Bill

The Committee Bill would extend the authority for “Express Lane” eligibility determinations until September 30, 2015.

SEC. 214. PEDIATRIC QUALITY MEASURES

Present Law

Section 401 of CHIPRA required the Secretary to: identify and publish an initial core set of pediatric quality measures; submit a report to Congress on the quality of children’s health care under Medicaid and CHIP; and to establish a Pediatric Quality Measures Program to identify pediatric measure gaps and development priorities, award grants and contracts to develop measures, and revise and strengthen the core measure set. States are required to submit reports to the Secretary annually to include information about state-specific child health quality measures applied by the state. The Secretary is required to collect, analyze, and make publicly available the information reported by states annually. Section 401 also included funding for ten grants to states for demonstration projects to evaluate ideas to improve the quality of children’s health care. Funding for these activities was appropriated in the amount of \$45 million for each of FY2009 through FY2013.

Committee Bill

The Committee Bill would modify the funding for adult quality measure development in SSA section 1139B to require the Secretary to spend at least \$15 million of the \$60 million appropriated on pediatric quality measure development under SSA section

1139A instead. This would provide the Secretary with the funding needed to continue the development of pediatric quality measures established under CHIPRA section 401(b) through September 30, 2015.

The Committee Bill would also eliminate a requirement that limits the aggregate amount the Secretary could award for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based adult quality measures.

SEC. 215. SPECIAL DIABETES PROGRAM

Present Law

The BBA authorized two diabetes-related programs within the Public Health Service Act. The first, authorized in section 330B, provides funding for the National Institutes of Health to award grants for research into the prevention and cure of Type I diabetes. The second, authorized in Section 330C, provides funding for the Indian Health Service (IHS) to award grants for services related to the prevention and treatment of diabetes for American Indians and Alaska Natives who receive services at IHS-funded facilities. Since the BBA, additional funding for this program has been appropriated in a series of laws, most recently in section 625 of the ATRA which extended funding for these programs through FY2014.

Committee Bill

The Committee Bill would extend funding for both programs through FY2019. Specifically, it would appropriate \$150 million for each program annually.

Subtitle C—Human Services Extensions

SEC. 221. ABSTINENCE EDUCATION GRANTS

Present Law

Section 912 of The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104–193) authorized abstinence education formula grants in SSA section 510. To receive these formula grants, states must request funding when applying for Maternal and Child Health Block Grant funds authorized in SSA section 501. Funds provided under SSA section 510 must be used exclusively for teaching abstinence from sexual activity outside of marriage. PRWORA authorized and appropriated \$50 million for each of FY1998 through FY2002 for abstinence education. Subsequently, funding for this program was extended through June 30, 2009, by a series of legislation. Most recently, section 2954 of the ACA appropriated \$50 million for each of FY2010 through FY2014 for this program. In addition, \$5 million was added to be used to award competitive grants for FY2012 by the Consolidated Appropriations Act of 2012 (P.L. 112–74) and the Consolidated and Further Continuing Appropriations Act of 2013 (P.L. 113–6). FY2014 is the final year of funding for this program.

Committee Bill

The Committee Bill would extend authorization and funding for the SSA section 510 Abstinence Education program for five years, from FY2015 through FY2019, at \$50 million for each year.

SEC. 222. PERSONAL RESPONSIBILITY EDUCATION PROGRAM

Present Law

Section 2953 of the ACA established the Personal Responsibility Education Program (PREP) in section 513 of the SSA. PREP is a state formula grant program to support evidence-based programs designed to educate adolescents about abstinence, contraception, and adulthood. The ACA also required the Secretary to award grants to implement innovative youth pregnancy prevention strategies and to target services to high-risk populations. The ACA appropriated \$75 million for each of FY2010 through FY2014. The ACA required that \$10 million each year be reserved for the youth pregnancy prevention grants. The funds are available until expended. FY2014 is the final year of funding for this program.

Committee Bill

The Committee Bill would extend authorization and funding for PREP for five years, from FY2015 through FY2019, at \$75 million for each year. The target population of the formula grant portion of the program would be expanded to include youth at risk for being a victim of sex trafficking or a victim of a severe form of trafficking in persons. The target population of the innovative strategies portion of the program would be expanded to include youth at risk for being a victim of sex trafficking or a victim of a severe form of trafficking in persons. The dates in the provision related to the mandatory use of unexpended allotments would be modified to conform to the five year extension of PREP. The base year for the maintenance-of-effort for non-federal funding would be changed from FY2009 to FY2014.

SEC. 223. FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS

Present Law

Section 6064 of the DRA established the Family-to-Family Health Information Centers program in SSA section 501(c). The program provides grants to family-staffed organizations that provide health care information and resources to families of children with special health care needs. The DRA appropriated \$12 million for FY2007 through FY2009 for Family-to-Family Health Information Centers; section 5507(b) of the ACA appropriated \$5 million for each of FY2009 through FY2012, with funding to remain available until expended. An additional \$5 million for FY2013 was included in section 624 of the ATRA. FY2013 was the final year of funding for this program.

Committee Bill

The Committee Bill would amend SSA section 501(c) to appropriate \$6 million for each of FY2014 through FY2018. The Bill would also add territories as eligible for the program by eliminating language in the subsection which defines “states” as the 50 states and the District of Columbia. This provision would be effective as if enacted on October 1, 2013.

SEC. 224. HEALTH WORKFORCE DEMONSTRATION PROJECT FOR LOW-INCOME INDIVIDUALS

Present Law

Section 5507(a) of the ACA requires the Secretary to establish a demonstration project under SSA section 2008(a) that award funds to states, Indian tribes, institutions of higher education, and local workforce investment boards for health profession opportunity grants (HPOG). These grants are designed to help provide low-income individuals—including individuals receiving assistance from the TANF program—to obtain education and training in health care jobs that pay well and are in high demand. Funds are also used to provide financial aid and other supportive services. The ACA appropriated \$85 million for each of FY2010 through FY2014 to carry out this demonstration project and another demonstration project established by the ACA, under SSA section 2008(b), to develop training and certification programs for long-term care workers. FY2014 is the final year of funding for this program.

Committee Bill

The Committee Bill would amend section 2008(c) of the SSA to extend funding of \$85 million for the HPOG demonstration under section 2008(a) of the SSA, for each of FY2015 and FY2016. In addition, the funding would continue to be streamlined and does not apply to the certification of home health aides for FY2013 through FY2016.

Subtitle D—Program Integrity

SEC. 231. REDUCING IMPROPER MEDICARE PAYMENTS

Present Law

CMS relies on a variety of contractors to help administer the Medicare program, including MACs for FFS Medicare. Section 911 of the MMA required the Secretary to implement Medicare contracting reform, which was intended to improve Medicare's administrative services through the use of competition and performance incentives. MACs process Medicare claims, and serve as the primary operational contact between the FFS program, and Medicare's approximate 1.5 million health care providers and suppliers. MACs enroll providers and suppliers in Medicare and educate providers on Medicare billing requirements, as well as answering provider and beneficiary inquiries.

MACs are required to educate providers about the fundamentals of the program, policies and procedures, new initiatives, and other significant changes. MACs also identify potential improper payment issues through analyses of provider inquiries, claim submission errors, medical review data, Comprehensive Error Rate Testing data, and the Recovery Audit Program data.

In addition to MACs, CMS also relies on other contractors that support program integrity activities such as Recovery Audit Contractors (RACs). Unlike other Medicare contractors, RACs are compensated on a contingency fee basis—their only payment is a percentage of the amount of each improper payment they identify, regardless of whether the claim was an overpayment or underpayment. RAC contingency fees vary depending on the contractor,

the type of claim, and the part of Medicare. RACs must return contingency fees when overpayments are overturned on appeals filed by the Medicare providers and suppliers. Overpayments identified by RACs are recouped by MACs and the amount of recouped funds less contingency fees paid to RACs and expenses for administering the RAC program are returned to the Medicare Trust Funds. RAC overpayment decisions that are appealed by providers affect the overpayment amount identified by RACs and the amount returned to the Medicare Trust Funds. The Medicare FFS appeals process has five levels: (1) the MACs, (2) Qualified Independent Contractors, (3) an Administrative Law Judge, (4) the Medicare Appeals Council, and (5) a federal court.

Committee Bill

The Committee Bill would require the Secretary to implement the following three initiatives: an improper payment outreach and education program; enhanced RAC transparency, and a RAC demonstration project.

The Committee Bill would require MACs to implement an improper payment outreach and education (OE) program. Each MAC would be required to have an improper payment OE program to provide outreach, education, training, and technical assistance activities to providers and suppliers in their geographic service areas. The improper payment OE would be conducted through the following: emails and other electronic communications, webinars, telephone calls, in-person training, and other forms of communications the Secretary deems appropriate. The information that would be conveyed through the improper payment OE program would include all of the following: (1) a list of each provider's and supplier's most frequent and expensive payment errors over the last quarter; (2) specific instructions on how to correct or avoid these errors in the future; (3) notice of all new procedures that the Secretary has approved for RACs; (4) specific instructions to prevent future issues related to new RAC procedures approved by the Secretary; and (5) other information the Secretary determines appropriate.

MACs would be required to ensure that all providers and suppliers in their geographic area are invited to participate (either in person or online) in an annual improper payment error rate reduction training.

The MAC OE program also would be required to include annual error rate reduction training. This training would give priority to reduce Medicare improper payments that: have the highest rate of improper payment; have the greatest total dollar amount of improper payments; are due to clear misapplication or misinterpretation of Medicare policies; are clearly due to common and inadvertent clerical or administrative errors; or are due to other error types the Secretary determined could be prevented by the error training rate reduction program.

To assist MACs in conducting the improper payment error reduction training program, the Secretary would be required to supply MACs on a quarterly basis with a complete list of improper payments identified by RACs for the providers and suppliers in the MACs region. The quarterly list of improper payments identified by RACs that the Secretary would be required to supply would include the following information: (1) the providers and suppliers that have

the highest improper payment rates; (2) the providers and suppliers that have the greatest improper payment amounts; (3) the items and services furnished in each MAC's geographic region that have the highest improper payment error rates; (4) the items and services in each MAC's geographic region that are responsible for the greatest improper payment amounts; and (5) other information the Secretary determines would be helpful to MACs in conducting the improper payment error reduction training program.

In providing information to assist MACs in conducting the improper payment error reduction training, the Secretary would be required to transmit that information so that it would be easy for MACs to identify the improper payment issues where outreach, education, training, and technical assistance would be most effective. The Secretary would ensure that information supplied to MACs was in an electronic and easily searchable format as well as that it clearly displayed the name and address of the provider or supplier, the amount of improper payment, and any other information the Secretary determines appropriate.

The Secretary would be authorized to retain up to 25 percent of the amounts recovered by the RAC program to implement the MAC OE program and to implement corrective actions to help reduce Medicare's error rate. The OE program requirements would be effective beginning on January 1, 2015.

The Committee Bill would add to the reporting requirements of the annual RAC report to Congress that is required under current law. Specifically, the Committee Bill would require information on the results of appeals at each appeal level for the following RAC review types: (1) automated, (2) complex, (3) medical necessity, (4) Part A, (5) Part B, and (6) durable medical equipment.

The Committee Bill would require the Secretary to conduct a three-year Medicare demonstration project to better target RAC audits. The demonstration would begin January 1, 2015. The Secretary would be required to consider the following in determining the demonstration's geographic area: a region's total number of providers and suppliers, the diversity of the region's providers and supplier types, the region's improper payment rate variation among individual providers and suppliers, and a mix of urban and rural providers and suppliers.

In conducting the demonstration, the Secretary would be required to identify the following two groups of providers and suppliers: (1) providers with low improper payment error rates, and (2) providers with high improper payment error rates. To assign a select group of providers and suppliers in the geographic region to one of these groups, the Secretary would be required to analyze the following as they relate to the total number and dollar amount of claims submitted: (1) the improper payment rates of individual providers of services and suppliers; (2) the amount of improper payments made to individual providers of services and suppliers; (3) the frequency of errors made by the provider of services or supplier over time; and (4) other information determined appropriate by the Secretary.

Only a small proportion of the total number of providers and suppliers in the demonstration's geographic area would be assigned to either the low error rate or the high error rate group. Providers and suppliers with high, expensive, and frequent improper pay-

ment errors would be identified as high-error providers and suppliers. Providers and suppliers with few, inexpensive, and infrequent errors would be identified as low error rate providers and suppliers.

Under the demonstration, the Secretary would be required to adjust the number of records that could be requested from providers and suppliers by RACs. The Secretary would be required to increase the maximum number of records that could be requested by RACs from providers and suppliers identified as having high error rates and decrease the maximum number of records that could be requested by RACs from providers and suppliers identified by composite scores as having low error rates.

The Secretary would have further authority under the demonstration to make additional adjustments to RAC requirements to offer incentives to reduce improper payment error rates for providers and suppliers assigned to either the low error rate group or the high error rate group. However, the Secretary would be prohibited from exempting any provider from being subject to RAC audits under the demonstration project.

The HHS Office of Inspector General (OIG) would be required to evaluate the RAC demonstration and submit a report to Congress within 12 months of completion of the RAC demonstration.

To implement the RAC incentive demonstration project, the Secretary would provide for the transfer of \$10 million to CMS's Program Management Account from the HI and the SMI Trust Funds in a proportion to be determined by the Secretary. These funds would be available until expended. In addition, the Secretary would be authorized to transfer to the OIG \$245,000 from the HI and SMI Trust Funds in a proportion to be determined by the Secretary.

SEC. 232. AUTHORITY FOR MEDICAID FRAUD CONTROL UNITS TO INVESTIGATE AND PROSECUTE COMPLAINTS OF ABUSE AND NEGLECT OF MEDICAID PATIENTS IN HOME AND COMMUNITY-BASED SETTINGS

Present Law

Medicaid Fraud Control Units (MFCUs) act upon complaints of abuse or neglect occurring in one of two settings: (1) Medicaid-funded "health care facilities" or (2) "board and care" facilities that receive payment from the Medicaid program.

Medicaid regulations (42 C.F.R. § 447.10(b)) define a "facility" as "an institution that furnishes health care services to inpatients" and separate regulations (42 CFR § 435.1010) define an "institution" as, "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor."

Section 1903(q)(4)(B) of the SSA defines "board and care facility" to mean "a residential setting which receives payment (regardless of whether such payment is made under the State plan under [Medicaid]) from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided: (i) Nursing care services . . . [and] (ii) A substantial amount of personal care services. . . ." Such facilities are typically identified as "assisted living facilities."

Section 1903(q) of the SSA does not permit payment for a MFCU's investigation or prosecution of abuse and neglect in a vari-

ety of settings outside of an institution or facility. The statute's limitation was logical when the MFCU program was established in 1978, at a time when Medicaid services were typically provided in an institutional setting, but has become outdated as the delivery and payment for health services has shifted to in-home and community-based settings.

Committee Bill

The Committee Bill allows payment to a MFCU that chooses to investigate and prosecute (or refer for prosecution) complaints of abuse or neglect of individuals in connection with any aspect of benefits or services provided by the state Medicaid program and for activities of providers of such benefits or services in a home or community based setting that is paid for under the state Medicaid program. The Committee Bill also allows payment to a MFCU that chooses to investigate and prosecute (or refer for prosecution) of complaints of abuse or neglect of patients residing in board and care facilities.

SEC. 233. IMPROVED USE OF FUNDS RECEIVED BY THE HHS INSPECTOR GENERAL FROM OVERSIGHT AND INVESTIGATIVE ACTIVITIES

Present Law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104–191) established the Health Care Fraud and Abuse Control Program (HCFAC). Funds from the HI Trust Fund are used to finance anti-fraud activities. These funds are shared by the Secretary, acting through the HHS OIG, and the Attorney General.

The TRHCA amended HIPAA so that the HCFAC funds may be available until expended and allowed for increases in the amount of funding for HCFAC annually, based on the change in the consumer price index. The ACA extended these increases permanently. The HCFAC funds typically constitute approximately three-fourths of the budget of the HHS OIG.

The HHS OIG conducts investigations, inquiries and utilizes other tools in order to combat fraud in health care. In furtherance of this goal, the HHS OIG staff and support the Medicare Strike Force, in conjunction with the Department of Justice, the FBI, and state and local enforcement agencies. The Strike Force focuses its efforts on investigating and prosecuting entities that defraud Medicare and other government health care programs. Other tools utilized by the HHS OIG include excluding providers and suppliers who have engaged in fraud from Medicare and Medicaid. HHS OIG also may impose civil monetary penalties for false claims against the government, audit and evaluate questionable conduct by providers, oversee the activities of all Medicaid Fraud Control Units, operate the HEAT Provider Compliance Training Initiative (which provides compliance training for providers), and offer advisory opinions.

Committee Bill

The Committee Bill allows the HHS OIG to receive and retain three percent of funds collected as a result of civil debt collect actions related to false claims or fraud under Medicare and Medicaid.

The Committee Bill would require this funding to be designated for oversight and enforcement activities conducted by the HHS OIG.

SEC. 234. PREVENTING AND REDUCING IMPROPER MEDICARE AND
MEDICAID EXPENDITURES

Present Law

Program integrity (PI) initiatives are designed to combat fraud, waste, and abuse. This includes processes directed at reducing improper payments, as well as activities to prevent, detect, investigate, and ultimately prosecute health care fraud and abuse. PI encompasses a broad range of activities intended to ensure proper payments are made. These activities can include post-payment claim reviews as well as pre-payment claims monitoring. PI emphasis has shifted from post-payment to pre-payment review to replace costly and time-consuming pay-and-chase methods with processes to prevent improper payments from being made. One of the most important prevention activities is to carefully scrutinize and block or otherwise restrict participation by providers that are at higher risk of committing fraud.

CMS shares responsibility for combating health care fraud with the HHS OIG, the Department of Justice, and the Federal Bureau of Investigation. Initially, Medicare contractors, called fiscal intermediaries (Part A) and carriers (Part B) were responsible for all PI activities. As the Secretary and government oversight entities recognized risks to the program, CMS tightened PI requirements on fiscal intermediaries and carriers.

CMS relies on a variety of contractors to help administer the Medicare program, including MACs for FFS Medicare. Section 911 of the MMA required the Secretary to implement Medicare contracting reform which was intended to improve Medicare's administrative services through the use of competition and performance incentives. MACs process Medicare claims, and serve as the primary operational contact between the FFS program, and Medicare's approximately 1.5 million health care providers and suppliers. MACs enroll providers and suppliers in Medicare and educate providers on Medicare billing requirements, in addition to answering provider and beneficiary inquiries.

MACs are required to educate providers and their staffs about the fundamentals of the program, policies and procedures, new initiatives, and other significant changes. MACs also identify potential improper payment issues through analyses of provider inquiries, claim submission errors, medical review data, Comprehensive Error Rate Testing data, and the Recovery Audit Program data.

In addition to MACs, CMS also relies on other contractors that support program integrity activities such as RACs. In FFS Medicare, RACs focus primarily on post-payment claim review and identification of overpayments to be recouped by MACs, although they also indirectly provide insight to CMS and other Medicare contractors on topics for provider education and outreach and identification of fraud and abuse vulnerabilities. In a March 2010 report, GAO indicated that CMS had not established processes to ensure that vulnerabilities identified by RACs were effectively communicated to other Medicare entities and that there was limited fol-

low-up to ensure that these contractors implemented measures to reduce these vulnerabilities.

In general, under MMA, Part D prescription drug plan sponsors must comply with certain requirements to assist CMS in administering and monitoring the program, including effective program integrity safeguards. Part D plans must submit to CMS an electronic prescription drug event (PDE) record for each covered prescription the plan fills for their enrollees. PDEs are similar to other health claim forms and contain a number of fields that enable CMS to determine plan payments and oversee the benefit. CMS requires that most PDEs contain a drug prescriber's identifier. Acceptable identifiers include the NPI, Drug Enforcement Administration registration numbers, Unique Physician Identification Numbers, and state license numbers. However, some drug prescribers are not considered covered entities under HIPAA and therefore may not be required to obtain an NPI (covered entities include health plans, health care clearinghouses, and health care providers that submit claims electronically). CMS instructed plans that non-NPI prescriber identifiers may be used on PDEs when the prescriber does not have an NPI, but that plans and pharmacies should make reasonable efforts to submit NPIs in the PDE prescriber field. Prescriber identifiers are valuable program integrity safeguards, in that they can indicate if legitimate practitioners prescribed an enrollee's drugs. Valid identifiers make it possible for plans and CMS to review claims and to investigate who prescribed covered drugs. In a June 2010 report, the HHS OIG found that there were a number of Part D claims with invalid prescriber identifiers and these claims accounted for \$1.2 billion in Medicare Part D expenditures.

The Secretary is required to submit an annual report to Congress on the use of RACs. These reports include information on the performance of RACs in identifying under- and over payments and in recouping overpayments.

The Federal Office of Child Support Enforcement (OCSE) operates the National Directory of New Hires (NDNH), a database established by the PRWORA. The primary purpose of the NDNH is to assist state child support agencies in locating parents and enforcing child support orders; however, Congress has only authorized specific state and federal agencies to receive information from the NDNH for a limited set of authorized purposes.

The NDNH is a national database of wage and employment information. Its primary purpose is to assist state child support agencies in locating noncustodial parents, putative fathers and custodial parties in order to establish paternity and child support obligations, as well as to enforce and modify orders for child support, custody and visitation. The NDNH is located at the Social Security Administration's National Computing Center. NDNH data are only available to specific entities for authorized purposes, which include the Secretary of the Treasury, state foster care and adoption assistance agencies, state welfare agencies, state child and family services agencies, the Social Security Commissioner, the Secretary of Education, and some de-identified uses by researchers. Statutory authority is required to receive NDNH information or to request an information comparison. OCSE may not disclose NDNH information without appropriate statutory authority.

The federal government and states contribute equally to fund most Medicaid and CHIP PI activities, although for some activities, the federal government provides additional funds through enhanced Federal Medical Assistance Percentage (FMAP) matching rates. All states receive the same FMAP rate for administrative expenditures, including most PI activities, which is generally 50%.

Under section 4735 of the BBA, states were required to submit Medicaid data to CMS using the Medicaid Statistical Information System (MSIS). In addition, each state is required to have its own Medicaid Management Information System (MMIS), and integrated group of procedures and computer processing operations that functions as a claims processing and information retrieval system. The Secretary must approve states' MMISs and have found them to meet a number of requirements including compatibility with Medicare claims processing and information systems, and consistency with uniform coding systems for claims processing and data interchange. Among other requirements, MMISs also must be capable of providing timely and accurate data, meet other specifications as required by the Secretary, and provide for electronic transmission of claims data as well as be consistent with MSIS data formats. A 90 percent federal match is available for MMIS design, development, or installation and a 75 percent federal match is available for the operation of an approved MMIS.

Each state has its own MMIS which it uses to process claims and monitor service use, but CMS maintains MSIS data for all states. CMS's MSIS data is an extract of states' MMISs and contains enrollee and claims information from all 50 states and the District of Columbia. MSIS is used for analytical research, program integrity, planning, budgeting, and Medicaid policy analyses. MSIS is the only nationwide Medicaid eligibility and claims database, although CMS is developing other data systems to help monitor and assist states in administering the Medicaid program.

More recently, section 6402 and 6504 of the ACA strengthened this provision by requiring states to include data elements the Secretary determines necessary for program integrity, program oversight, and administration, including managed care encounter data.

In 2005, the DRA amended the SSA to add section 1936 established the Medicaid Integrity Program (MIP). Section 1936 appropriated as much as \$75 million annually in MIP funding to support and enhance state PI efforts by expanding and sustaining national activities such as provider audits, overpayment identification, and payment integrity and quality of care education. Section 1936, as originally enacted, restricted how MIP funding could be used and required that the Secretary employ a specified number of full-time equivalent staff. Section 1936 also restricted MIP funding to contractor payments and limited the Secretary's ability to use MIP funds for equipment, travel, benefits, training, and salaries.

In addition to establishing the MIP, section 6034 of the DRA established the Medicare-Medicaid Data Match (Medi-Medi) Program. The Medi-Medi program was created to help identify Medicare and Medicaid program integrity vulnerabilities using computer algorithms (billing or billing patterns related to service, time, or patients that appear suspect or otherwise implausible).

Under the Medi-Medi program, state participation is voluntary. States receive no direct support other than their FMAP administra-

tive match of 50%. Medicare Program Safeguard Contractors (PSCs) conducted most of the analysis. Ten states volunteered to participate in the Medi-Medi program. In an April 2012 report, the HHS OIG found that the Medi-Medi program produced limited results and benefitted Medicare more than Medicaid. HHS OIG recommended that the Secretary make changes to the Medi-Medi program.

Another program integrity area where Medicare and Medicaid coordination could be important is reviewing and monitoring expenditures for individuals dually eligible for both programs. Although dual eligible beneficiaries are only approximately 25% of both programs' enrollment, they account for approximately 75% of the programs' expenditures, so monitoring their service use is important. However, because there are shared responsibility for the cost of dual eligibles' care, oversight of these expenditures, including program integrity, can be fragmented and lack direct timely, accurate data on utilization.

Committee Bill

The Committee Bill prohibits, for 2015 and for each subsequent year, Prescription Drug Plans from paying claims for prescription drugs under Part D that do not include a valid prescriber NPI.

The Committee Bill requires that the annual report to Congress on RACs for 2015 and each subsequent year include a description of (1) the types and financial cost to Medicare of improper payment vulnerabilities identified by RACs and (2) how the Secretary is addressing such improper payment vulnerabilities. The Committee Bill also requires the annual report to Congress include an assessment of the effectiveness of changes made to payment policies and procedures in Medicare in order to address the vulnerabilities so identified.

The Committee Bill allows the Secretary to use MIP funding for equipment, travel, benefits, training and salaries. The Committee Bill also allows MIP funding to be used to employ a number of staff as the Secretary determines necessary to carry out PI.

The Committee Bill requires the Administrator of CMS have access to the information in the NDNH for purposes of determining the eligibility of an applicant for, or enrollee in, Medicare or a state health subsidy program.

The Committee Bill requires that if the HHS OIG transmits to the Secretary the names and Social Security Numbers of individuals, the Secretary must disclose to the HHS OIG information on such individuals and their employers maintained in the NDNH. The HHS OIG may use this information only for the purposes of determining eligibility of an applicant for, or enrollee in, Medicare or a state health subsidy program or evaluating the integrity of the Medicare program or a state health subsidy program.

If, for the purposes of determining eligibility, a state health subsidy program transmits to the Secretary the names, dates of birth and Social Security Numbers of individuals, the Secretary must disclose to the state agency information on such individuals and their employers maintained in the NDNH.

The Committee Bill requires the Secretary to establish a plan to encourage and facilitate the participation of states in the Medicare-Medicaid Data Match Program, or Medi-Medi Program. The Com-

mittee Bill requires the Secretary to develop and implement a plan that allows state Medicaid programs access to relevant data on improper or fraudulent payments made under Medicare. The Committee Bill makes technical changes to the Medi-Medi program to improve the participation of states.

Subtitle E—Other Provisions

SEC. 241. COMMISSION ON IMPROVING PATIENT DIRECTED HEALTH CARE

Present Law

No provision.

Committee Bill

The purpose of section 241 of the Committee Bill would be to create a Commission on Improving Patient Directed Health Care, which is a 15-member group charged with providing a forum for nationwide public debate in improving patient self-determination in health care decision-making; identifying strategies to ensure every American receives the health care they want; and providing recommendations to Congress. The Commission, which includes the Secretary and 14 GAO-appointed members selected to represent a diverse range of perspectives and experience, will conduct hearings across the country to allow Americans to provide input. The Commission will issue a Report to the American People on Patient Directed Health Care that, among other things, summarizes what the Commission learned at its hearings and solicits comment from the public. Following close of the public comment period, the Commission will submit recommendations to the President and Congress. The Bill makes \$3,000,000 available in each of fiscal years 2014 and 2015 for the Commission to conduct its work.

SEC. 242. EXPANSION OF THE DEFINITION OF INPATIENT HOSPITAL SERVICES FOR CERTAIN CANCER HOSPITALS

Present Law

From the outset of the Medicare program, the statute and regulations have expressly authorized payment for services furnished “under arrangement” between a provider and an outside vendor. Medicare will pay for diagnostic and other therapeutic services if furnished by others under arrangement with the hospital as long as the hospital exercises some oversight over the vendor. Medicare statute specifies that routine services, including bed, board and nursing, are to be provided by the hospital. In FY2012, CMS implemented a regulation that would require hospitals to provide routine services directly and not under arrangement with other providers. Enforcement of this regulation has been delayed until January 1, 2015.

There are 11 cancer hospitals that are exempt from Medicare’s IPPS used to pay acute care hospitals. Some of these cancer hospitals are located in the same building or on the same campus as another hospital and obtain routine services under arrangement with other providers.

Committee Bill

The Committee Bill would permit cancer hospitals that are located in the same building or on the same campus as another hospital as of the date of enactment to obtain routine services furnished after enactment under arrangement.

SEC. 243. QUALITY MEASURES FOR CERTAIN POST-ACUTE CARE PROVIDERS RELATING TO NOTICE AND TRANSFER OF PATIENT HEALTH INFORMATION AND PATIENT CARE PREFERENCES

Present Law

To differing degrees, acute care hospitals and other Part A providers are subject to pay-for-reporting and pay-for-performance requirements under the Medicare program that can use endorsed measures from a consensus-based entity such as the National Quality Forum.

Committee Bill

The Committee Bill would require the Secretary to provide for the development of one or more Medicare quality measures to accurately communicate the existence and provide for the transfer of patient health information and patient care preferences when an individual is discharged from a hospital to return home or to other post-acute care settings. The Secretary would arrange for the development of these measures by appropriate measure developers that would submit the measures for endorsement by a consensus-based entity. These measures would be included through notice and comment rulemaking in different quality reporting programs for acute care hospitals, skilled nursing facilities, home health agencies and, as determined by the Secretary, other appropriate providers and suppliers.

SEC. 244. CRITERIA FOR MEDICALLY NECESSARY, SHORT INPATIENT HOSPITAL STAYS

Present Law

CMS established regulations to provide guidance on the appropriateness of a Medicare inpatient admission as part as its FY2014 IPPS rulemaking. Inpatient hospital stays that are ordered by physicians with appropriate documentation in the patient's medical record that span (or are expected to span) two midnights at the hospital will generally be presumed to be medically appropriate admissions. CMS has delayed implementation of this requirement for six months until March 31, 2014.

Committee Bill

The Committee Bill would require the Secretary to consult with and seek input from interested stakeholders to determine appropriate criteria to determine medically necessary care that is an inpatient hospital stay that is less than two midnights (as established by 42 CFR 412.3 finalized in the FY2014 IPPS rule). Stakeholders would be hospitals, physicians, MACs, RACs, and other appropriate parties as determined by the Secretary.

SEC. 245. TRANSPARENCY OF REASONS FOR EXCLUDING ADDITIONAL
PROCEDURES FROM THE MEDICARE AMBULATORY SURGICAL CENTER
(ASC) APPROVED LIST

Present Law

Covered surgical procedures in an ambulatory surgical center (ASC) are surgical procedures that are separately paid under the OPPS, that would not be expected to pose a significant risk to beneficiary safety when furnished in an ASC, and that would not be expected to require active medial monitoring and care at midnight following the procedure.

The criteria used to identify a significant safety risk when furnished in an ASC include, but are not limited, to those procedures that: generally result in extensive blood loss; require major or prolonged invasion of body cavities; directly involve major blood vessels; are generally emergent or life threatening in nature; or commonly require systemic thrombolytic therapy. Medicare will not cover unlisted procedures associated with a specific anatomic location (for example, unlisted codes associated with eye procedures) in an ASC. Also, certain procedures have been designated as covered only when provided in an inpatient setting.

CMS updates the lists of covered surgical procedures and ancillary services in ASCs as part of the ASC annual rulemaking process. For CY2014, commenters requested that CMS add 54 additional surgical procedures to the list of ASC covered surgical procedures. Of these codes, CMS did not review 15 procedures that were either unlisted codes (2), only covered on an inpatient basis (6), or already covered in an ASC (7). Of the 39 remaining codes, four were included on the ASC covered surgical procedure list starting with CY2014. CMS determined that the remaining 35 codes were not appropriate to perform in an ASC, but did not provide a reason to justify its decision for each code.

Committee Bill

The Committee Bill would require that the Secretary describe the specific safety criteria for not including the requested procedure on the list of ASC covered procedures.

SEC. 246. SUPERVISION IN CRITICAL ACCESS HOSPITALS

Present Law

Medicare provides coverage for a wide range of diagnostic and therapeutic services in HOPDs. In the CY2009 hospital OPPS final rule published on November 18, 2008, CMS codified a longstanding expectation that hospital outpatient therapeutic services provided ‘incident to’ a physician must be under the direct supervision of a physician. The term “physician” refers to (1) a doctor of medicine or osteopathy legally authorized to practice in their state; (2) a doctor of dental surgery or dental medicine; (3) a doctor of podiatric medicine; (4) a doctor of optometry; (5) a chiropractor, or (6) a clinical psychologist. Additionally, the term “direct supervision” requires that such physician be on the hospital premises (or department premises for off-campus hospital departments) and immediately available to furnish assistance and direction throughout the

performance of the service or procedure if the need arises, but not necessarily in the room of service.

In the CY2010 final rule, after receiving comments from stakeholders, CMS modified the direct supervision requirement for hospital outpatient therapeutic services. Effective January 1, 2010, nurse practitioners, physician assistants, clinical nurse specialists, or certified nurse-midwives authorized under state law could also provide and meet the direct supervision requirement. Additionally, CMS implemented a technical correction which clarified that the direct supervision requirement applied to both hospitals and CAHs—a specific type of small rural hospitals.

On March 15, 2010, in consideration of stakeholder comments, CMS issued a notice of non-enforcement of the direct supervision of outpatient therapeutic services in CAHs for CY2010. While CAHs remained subject to the direct supervision standard, contractors were instructed not to evaluate or enforce the direct supervision standard against such hospitals. In the CY2011 final rule, the notice of non-enforcement was extended through CY2011 and applied to small rural hospitals with 100 beds or fewer that did not otherwise meet the definition of a CAH. In the CY2012 final rule, the notice of non-enforcement was extended for CYs 2012 and 2013. Additionally, CMS established a Hospital Outpatient Payment Panel to advise CMS on appropriate supervision levels other than direct supervision for specific outpatient hospital therapeutic services. Beginning January 1, 2014, the direct supervision requirement will be enforced for certain hospital outpatient therapeutic services provided in CAHs and small rural hospitals.

Committee Bill

Section 246 of the Committee Bill would allow general supervision by a physician at CAHs for payment of therapeutic hospital outpatient services.

Additionally, professionals including: (1) a doctor of medicine or osteopathy legally authorized to practice in their State; (2) a doctor of dental surgery or dental medicine; (3) a doctor of podiatric medicine; (4) a doctor of optometry; (5) a chiropractor, or (6) a clinical psychologist, at CAHs may directly supervise cardiac and pulmonary rehabilitation. This fixed a technical problem that prohibits non-physician practitioners from directly supervising cardiac and pulmonary rehabilitation services.

SEC. 247. REQUIRING STATE LICENSURE OF BIDDING ENTITIES UNDER THE COMPETITIVE ACQUISITION PROGRAM FOR CERTAIN DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

Present Law

Under Medicare's competitive bidding program, CMS may only award contracts to suppliers if the following requirements are met: (1) the supplier is accredited by a CMS-approved national accrediting organization, (2) the supplier meets applicable financial standards specified by the Secretary, (3) the total amount to be paid under contracts in competitive bidding areas is expected to be less than amounts that would be paid under the fee schedule meth-

odology, and (4) beneficiaries have a choice of multiple suppliers in each area.

Suppliers must also be in good standing with an active Medicare provider number, meet all applicable state and federal regulatory and licensure requirements, and be ready to provide services on the first day of the contract period.

Committee Bill

For rounds of competitive bidding beginning on or after the enactment of the Committee Bill, the Secretary may only accept a bid from an entity for an area if the entity already meets applicable state licensure requirements for such area for all items in such bid.

SEC. 248. RECOGNITION OF ATTENDING PHYSICIAN ASSISTANTS AS
ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS

Present Law

Currently, under Medicare, physicians and nurse practitioners can serve as attending physicians for beneficiaries during hospice care. Physician assistants are not permitted to serve as a beneficiary's attending physician under the hospice benefit services.

Committee Bill

The Committee Bill would amend section 1861(dd)(3)(B) and section 1814(a)(7)(A)(i)(I) of the SSA to allow physician assistants, in addition to physicians and nurse practitioners, to be attending physicians reimbursed for the services furnished they provide during hospice care. The amendments do not grant physician assistants the authority to order hospice care for beneficiaries.

SEC. 249. REMOTE PATIENT MONITORING PROJECT

Present Law

Under certain circumstances, the Medicare program provides reimbursement for remote monitoring under the physician fee schedule

Committee Bill

The Committee Bill would require the Secretary of Health and Human Services to create pilot projects that incentivize home health agencies and other entities to purchase and utilize remote patient monitoring and communications technologies. Home health agencies participating in the pilot would receive an incentive payment based on a percentage of the Medicare savings realized as a result of the pilot projects.

The incentive payments would not exceed the amount that the Secretary estimates would be expended to home health agencies if the pilot projects had not been implemented. These technologies must both enhance health outcomes for Medicare beneficiaries and reduce total spending under the Medicare program.

Incentive payments would not reduce the payments that home health agencies would otherwise receive for providing home health benefits to Medicare beneficiaries, and performance targets would be established based on historic spending in Medicare.

The pilot projects would be conducted in both urban and rural areas and at least one project would be conducted in a state with a population of less than one million.

The Secretary would conduct a study on the appropriate valuation of remote patient monitoring services under the Medicare physician fee schedule in order to accurately reflect the resources used in furnishing such services. Not later than six months after the date of enactment of the Committee Bill, the Secretary would submit to Congress a report on the study referenced above.

SEC. 250. COMMUNITY-BASED INSTITUTIONAL SPECIAL NEEDS PLAN
DEMONSTRATION PROGRAM

Present Law

Section 231 of the MMA established a new type of MA coordinated care plan to focus on individuals with special needs. SNPs are allowed to target enrollment to one or more types of special needs individuals including individuals who are institutionalized or who require nursing home level of care. These types of SNPs are referred to as Institutionalized SNPs (I-SNPs).

The Committee Bill

The Committee Bill requires the Secretary to conduct a Community-Based Institutional Special Needs Plan demonstration program aimed at preventing and delaying institutionalization of Medicaid beneficiaries enrolled in plans participating in the demonstration. The demonstration would include up to five I-SNPs that have experience offering services to enrollees who live in the community and are located in a state that has agreed to participate in the demonstration. These participating plans would be required to provide certain long term care services and supports as a supplemental benefit to their enrollees. The plans participating in the demonstration would enroll beneficiaries who are eligible for the low-income subsidy under Part D and who are unable to perform two or more activities of daily living.

The demonstration would begin no later than January 1, 2016 and would last three years. An independent evaluation will be required to determine whether the demonstration has reduced hospitalization (or re-hospitalizations), Medicaid nursing home facility stays, and spend down of income and assets for purposes of becoming eligible for Medicaid. \$3 million is made available for the demonstration and \$500,000 is available for the evaluation.

SEC. 251. APPLYING CMMI WAIVER AUTHORITY TO PACE IN ORDER TO
FOSTER INNOVATIONS

Present Law

Section 3021 of the ACA created the CMMI within CMS. CMMI is tasked with testing innovative payment and delivery system reforms that improve quality or reduce costs. In order to test innovations under CMMI, the Secretary is permitted to waive requirements in titles XI and XVIII of the SSA but only three specific portions of title XI: 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii). CMMI is not permitted to waive the Medicaid requirements of the Programs of All-Inclusive Care for the Elderly (PACE) program.

The PACE program is a provider-based program that serves frail, elderly Medicare and Medicaid beneficiaries. PACE providers receive separate payments from Medicare and Medicaid and provide both Medicare and Medicaid services. The eligibility to receive services from a PACE provider is more stringent than Medicare and Medicaid eligibility standards. Individuals eligible to enroll must: (1) be 55 years of age or older, (2) require the level of care for nursing home coverage under a state Medicaid program, and (3) reside in the service area of a PACE program.

The Committee Bill

The Committee Bill provides the Secretary the authority to waive applicable Medicaid requirements of the PACE program in order to conduct demonstration projects through CMMI that involve PACE. The Committee Bill prohibits the Secretary from waiving the requirement to offer items and services covered under Medicare (1934(b)(1)(A)) and the requirements regarding enrollment in and disenrollment from PACE programs (1934(c)(5)) as part of a CMMI demonstration.

SEC. 252. IMPROVE AND MODERNIZE MEDICAID DATA SYSTEMS AND REPORTING

Present Law

Current law includes data system requirements applicable to states and the Secretary; however, current law does not specifically require the Secretary to submit a Medicaid data systems strategic plan to Congress. Under section 4735 of the BBA states were required to submit Medicaid data to CMS using the Medicaid Statistical Information System (MSIS), thus creating some common data definitions and standards. More recently, section 6405 of the ACA strengthened this provision by requiring states to include data elements the Secretary determines necessary for program integrity, program oversight, and administration, including managed care encounter data.

Each state has its own MSIS which it uses to process claims and monitor service use, but CMS maintains a national MSIS for all states. MSIS is the only nationwide Medicaid eligibility and claims database, although CMS is developing other data systems to help monitor and assist states in administering the Medicaid program. The GAO and the HHS OIG have identified MSIS data shortcomings such as inaccuracies, insufficient data for conducting program integrity functions, redundancy, and outdated information. CMS initiated a pilot, call Transformed-MSIS (T-MSIS), in March 2011 as a continuation of past MSIS improvement efforts. CMS indicated that it plans to transition all states to T-MSIS by July 1, 2014. In a March 2011 report, the Medicaid and CHIP Payment Advisory Commission recommended that CMS implement a strategic plan to address redundancies and gaps in Medicaid data.

Committee Bill

The Committee Bill directs the Secretary to implement a strategic plan to increase the usefulness of data about state Medicaid programs reported by states to CMS. The strategic plan would address redundancies and gaps in Medicaid data systems and report-

ing through improvements to, and modernization of, computer and data systems. Areas for improvement under the plan would include the following: (1) the reporting of encounter data by managed care plans; (2) the timeliness and quality of reported data, including enrollment data; (3) the consistency of data reported from multiple sources; and (4) information about state program policies. Within a year of enactment of the Committee Bill, the Secretary is required to submit a report to Congress on the status of the implementation of the strategic plan.

SEC. 253. FAIRNESS IN MEDICAID SUPPLEMENTAL TRUSTS

Present Law

The Omnibus Budget Reconciliation Act of 1993 (OBRA93; P.L. 103–66) established two trusts that are commonly utilized by individuals with disabilities to maintain assets while not endangering their eligibility for public benefits. Specifically, section 1396p(d)(4)(A) and section 1396p(d)(4)(C) of the SSA, known as section (d)(4)(A) and (d)(4)(C) trusts respectively, exempt the assets held therein from counting for purposes of Medicaid and Supplemental Security Income eligibility. A section (d)(4)(C) trust may be created by a parent, grandparent, legal guardian, or individuals themselves, and is held and managed by a third-party for the benefit of the individual with a disability. However, a section (d)(4)(A) trust may be created only by the parent, grandparent, legal, or a court, not individuals themselves.

Committee Bill

The Committee Bill would allow an individual with a disability, who otherwise qualifies for a section (d)(4)(A) trust, to create the trust independently.

SEC. 254. HELPING ENSURE LIFE- AND LIMB-SAVING ACCESS TO PODIATRIC PHYSICIANS

Present Law

For the purposes of Medicaid, a physician is a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she practices. The definition does not include doctors of podiatric medicine. As a result, foot and ankle care services provided by a podiatrist are considered an optional benefit and are not covered by all state plans.

Under Medicare, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes must meet a number of conditions in order to be considered covered services. The individual's managing physician must document that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation. Additionally, the physician must certify that the individual needs such shoes under a comprehensive plan of care related to the diabetic condition. A podiatrist or other qualified physician must prescribe the particular type of shoes. The shoes must be fit and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician certifying the need for the shoes. However, the physician certi-

fying the need for shoes can also fit and furnish them if the Secretary finds that the physician is the only such qualified individual in the area.

Committee Bill

Effective upon the date of enactment, the Committee Bill would amend Medicaid's definition of physician under section 1905(a)(5)(A) to include a doctor of podiatric medicine as defined under section 1861(r) of Medicare. The Committee Bill allows states requiring legislation to comply with the change additional time to do so.

Effective for items and services furnished on or after January 1, 2015, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes would have to meet a different set of conditions in order to be considered covered services. The physician managing the individual's diabetic condition would have to:

- (1) Document that the individual has diabetes,
- (2) Certify that the individual is under a comprehensive plan of care related to a diabetic condition, and
- (3) Document agreement with the prescribing podiatrist or other qualified physician that the shoes are medically necessary.

Additionally, the therapeutic shoes would have to be prescribed by a podiatrist or other qualified physician who:

- (1) Examines the individual and determines the medical necessity for the individual to receive the therapeutic shoes, and
- (2) Communicates in writing to the individual's managing physician that therapeutic shoes are medically necessary as well as findings that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, previous amputation, or poor circulation.

The shoes would be fit and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician certifying the need for the shoes. However, the physician certifying the need for the shoes would also be able to fit and furnish them if the Secretary finds that the physician is the only such qualified individual in the area.

SEC. 255. DEMONSTRATION PROGRAM TO IMPROVE COMMUNITY
MENTAL HEALTH SERVICES

Present Law

Under current law, CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) collaborate on several issues. Both the CMS Administrator and the SAMHSA Administrator sit on the Task Force on Aging Research. The Secretary, acting through the SAMHSA Administrator, is required to promote the coordination of programs relevant to individuals with mental illness or substance abuse, in part through liaisons with CMS. The duties of the Director of SAMHSA's Center for Substance Abuse Treatment include collaborating with the CMS Administrator to promote integration of substance abuse treatment into the main-

stream of the health care system. The Secretary is required to ensure that CMS, SAMHSA, and other agencies coordinate the planning, funding, and implementation of federal HIV programs.

There is no statutory definition of a behavioral health clinic; however, statutory requirements do exist for three similar types of facilities, each in the context of a specific program (e.g., a grant or Medicare Part B). The first is a mental health center, which must provide: services principally to individuals residing in geographically defined service areas; a series of specified outpatient services; 24-hour emergency care services; day treatment, partial hospitalization services, or psychosocial rehabilitation services; and screening for patients being considered for admission to state mental health facilities. Such services must be provided to any individual residing or employed in the service area, regardless of ability to pay; services must be available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care. The second is a community mental health center, which also provides the services specified above for mental health centers; in addition they must meet applicable state licensing or certification requirements and provide at least 40 percent of their services to individuals who are not Medicare beneficiaries. The third is an emergency mental health center, which must serve as a central receiving point for individuals in need of emergency mental health services; provide necessary mental health treatment or a referral for such treatment; purchase any necessary equipment; and provide any necessary training to the medical staff. Such centers may also establish and train a mobile crisis intervention team.

States establish and administer their Medicaid programs and determine the type, amount, duration, and scope of covered services within broad federal guidelines. For example, states must cover certain mandatory benefits and may choose to cover optional benefits listed in Medicaid statute. In general, Medicaid covered services must meet a "statewideness" requirement whereby states must provide the same amount, duration and scope of coverage for a given benefit throughout the entire state.

Federal Medicaid statute does not specify the exact types of mental health services that can be reimbursed. However, all state Medicaid programs cover some mental health services, whether through state plan services, the Early and Periodic Screening, Diagnostic and Testing benefit, or waiver programs. Medicaid reimbursement is available for mental health services under various Medicaid service categories, including: physician services, inpatient and outpatient hospital services, clinics, rehabilitative services, inpatient psychiatric hospital services for individuals under age 21, and prescription drugs. Examples of services in these categories include counseling, therapy, medication management, psychiatrist services, licensed clinical social work services, peer supports, and substance abuse treatment. Individuals may receive services in their homes, other residences, schools, or medical institutions, if necessary.

The federal government and the states jointly finance Medicaid. The federal government reimburses states for a portion of each state's Medicaid program costs. The federal government's share of most Medicaid expenditures is established by the FMAP rate. A state's share of program spending for Medicaid is equal to 100 per-

cent minus the FMAP. CHIP is also jointly financed by the federal government and the states using a matching scheme. The federal government pays a larger share for CHIP than it does for Medicaid. The enhanced FMAP (E-FMAP) for CHIP means a state's share of expenditures is 30 percent lower than under the regular FMAP.

Federal laws and regulations govern the time and manner in which state Medicaid agencies pay providers. For most Medicaid providers, states develop their own methodologies for making Medicaid payments (e.g., they may pay providers by FFS, on a capitated basis, or under a combination of both). Federally qualified health centers (FQHCs) and rural health clinics (RHCs), which provide health care services to populations in areas where access to physician care has been limited, are unique in Medicaid in that federal statute specifies their reimbursement methodology referred to as a prospective payment system (PPS). Since January 2002, the law requires that each existing FQHC/RHC is entitled to a payment amount per visit equal to the amount for the previous fiscal year increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any change in the scope of services furnished.

For entities first qualifying as FQHCs and RHCs after 2000, the per visit payments begin in the first year that the center or clinic attains qualification and are based on 100 percent of the costs incurred during that year and the rates established for similar centers or clinics with similar caseloads in the same or adjacent geographic areas. In the absence of such similar centers or clinics, the methodology is based on that used for developing rates for established FQHCs or RHCs or such methodology or reasonable specifications as established by the Secretary. For each fiscal year thereafter, per visit payments for all FQHCs and RHCs are equal to amounts for the preceding fiscal year increased by the percentage increase in the MEI applicable to primary care services for that fiscal year, and adjusted for any increase or decrease in the scope of services furnished during that fiscal year. Under managed care contracts, states must make supplemental payments to the center or clinic equal to the difference between contracted amounts and the cost-based amounts. States are allowed to establish alternative payment methods but only when payments are at least equal to the amounts that would otherwise be provided under the PPS.

Committee Bill

The Committee Bill establishes a five-year demonstration program for up to ten states, setting new criteria for community behavioral health providers and allowing them to be reimbursed for a broad range of services. The Secretary, in coordination with the Administrator of SAMHSA, would award planning grants to the selected states.

To be eligible, states would be required to submit an application to the Secretary, conduct a financial assessment, comply with any other requirements as established by the Secretary, and certify that the behavioral health providers under the demonstration program meet certain specified criteria for certified clinics. States would also have to certify that providers of community mental health services meet new criteria and offer specific behavioral health services. Those services would then be reimbursed under

Medicaid using a PPS based on the PPS for FQHCs under section 1902(bb) of the SSA. Those services would also be eligible for an enhanced federal match rate as defined under section 2105(b). In selecting states for the demonstration, considerations will be made for geographic diversity of participating states, including representation of certified clinics in rural and other underserved areas within those states. The Secretary would be able to waive the Medicaid statewideness requirement, which would permit states to offer different service packages in different areas.

The certified clinics would have to provide a number of services under the new criteria including: (1) crisis psychiatric services available on a 24-hour basis as well as psychiatric screenings; (2) evidence-based and integrated treatment for mental illness, substance abuse, and trauma including cognitive behavioral therapy, applied behavioral analysis, and medication management; (3) peer support and counselor services for individuals and families; and (4) integrated preventive screenings for diabetes, hypertension, and cardiovascular disease.

The certified clinics would have to meet a number of additional requirements under the new criteria, including to: (1) demonstrate the capacity to comply with behavioral health and related healthcare quality measures; (2) form linkages or formal contracts with FQHCs, VA facilities, acute care hospitals, psychiatric hospitals, and other providers and social service organizations; and (3) provide outreach, engagement, and intensive community-based mental healthcare for members of the armed forces and veterans, particularly in rural areas.

The Committee Bill authorizes \$50 million to be appropriated to carry out this section.

SEC. 256. ANNUAL MEDICAID DSH REPORT

Present Law

The Medicaid statute requires states make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients. While most federal Medicaid funding is provided on an open-ended basis, federal Medicaid DSH funding is capped. Each state receives an annual federal DSH allotment, which is the maximum amount of federal matching funds that each state can claim for Medicaid DSH payments. In FY2013, the federal DSH allotments to states totaled \$11.5 billion. Medicaid DSH allotments will be reduced by \$1.2 billion in FY2016, \$1.8 billion in FY2017, \$5 billion in FY2018, \$5.6 billion in FY2019, and \$4.0 billion for FY2020 through FY2023. Under current law, in FY2024, states' DSH allotments will rebound to their pre-2014 reduced levels with the annual inflation adjustments for FY2014 to FY2024. Currently, federal statute requires states submit annual reports identifying each DSH hospital and other information as the Secretary determines necessary, which includes hospital-specific information such as Medicaid inpatient utilization rate and amount of uncompensated care.

Committee Bill

Under the Committee Bill, beginning January 1, 2015, the Secretary would annually submit a report to Congress on the Medicaid

DSH payments for the purpose of providing Congress with information relevant to determining an appropriate level of overall funding for the payment adjustments during and after 2014–2022, the period in which reductions to the DSH allotments are made.

Each report would have to include: (1) information regarding changes in the number of uninsured individuals over time; (2) information on the extent to which hospitals continue to incur uncompensated care costs; (3) the extent to which hospitals continue to provide charity care and incur bad debt; (4) in the first report submitted, a methodology for estimating the amount of unpaid patient deductibles, copayments, and coinsurance incurred by hospitals for patients enrolled in qualified health plans and in subsequent reports, data regarding such uncompensated care costs collected pursuant to such methodology; (5) for each state, the difference between the aggregate amount of uncompensated care costs for all disproportionate share hospitals and the state's DSH allotment in the prior year; (6) the extent to which there are certain vital hospitals that are disproportionately experiencing high levels of uncompensated care; and (7) any other relevant information on the appropriate level and allocation of funding that the Secretary determines appropriate.

SEC. 257. IMPLEMENTATION

Present Law

When Congress enacts legislation, Congress often grants rule-making authority to agencies, and agencies use that authority to set standards and prescribe the details of certain federal policies and programs. In issuing those regulations, agencies are generally required to follow a certain set of procedures that Congress has enacted into law. The most long-standing and broadly applicable federal rulemaking requirements are in the Administrative Procedure Act of 1946 (APA, P.L. 79–404).

In general, the APA requires agencies to issue a notice of proposed rulemaking (NPRM) prior to issuing a final rule (5 U.S.C. § 553(b)). Under the APA, the NPRM must contain either the “terms or substance of the proposed rule” or “a description of the subjects and issues involved.” The APA contains some exceptions to that requirement, including “interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice”; or “when the agency for good cause finds . . . that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.”

Following the notice of proposed rulemaking, agencies are generally required to take comments on the NPRM (5 U.S.C. § 553(c)). However, the same exceptions apply to the comment period that apply to the issuance of an NPRM (see above). The APA does not specify a minimum duration for the comment period. Unless specified in statute, the agency may determine the length of a comment period for a given rule, so long as it gives the public a meaningful opportunity to participate.

Similarly, the APA does not require agencies to issue their rules under any particular timeline. In many cases, agencies are required by or permitted under statute to issue rules without any deadlines.

Section 553(d) of the APA requires that, with some exceptions, agencies must have a 30-day period following the publication date of a rule before it can become effective. The APA's exceptions to that requirement are "(1) a substantive rule which grants or recognizes an exemption or relieves a restriction; (2) interpretative rules and statements of policy; or (3) as otherwise provided by the agency for good cause found and published with the rule."

Committee Bill

The Committee Bill would establish requirements for the issuance of implementing regulations for any section of the Bill. The Secretary would be required to, unless otherwise specified in the Committee Bill: (1) issue a notice of proposed rulemaking that includes the proposed regulation; (2) provide a period of not less than 60 calendar days for comments on the proposed regulation; and (3) publish the final regulation or take alternative action (such as withdrawing the rule or proposing a revised rule with a new comment period) on the proposed regulation, not more than 24 months following publication of the proposed rule and not less than 30 calendar days before the effective date of such final regulation.

LIST OF TERMS

ACA: The Patient Protection and Affordable Care Act (P.L. 111–148); the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111–152)
 APA: The Administrative Procedures Act of 1946 (P.L. 79–404)
 APM: Alternative payment model
 ARRA: The American Recovery and Reinvestment Act of 2009 (P.L. 111–5)
 ATRA: The American Taxpayer Relief Act (P.L. 112–240)
 BBA: The Balanced Budget Act of 1997 (P.L. 105–33)
 BPBA: The Bipartisan Budget Act of 2013 (P.L. 113–67)
 CAH: Critical access hospital
 CMMI: The Center for Medicare and Medicaid Innovation
 CMS: The Centers for Medicare and Medicaid Services
 C–SNP: Medicare Advantage special needs plan for individuals with specific, severe or disabling chronic conditions
 DRA: The Deficit Reduction Act of 2005 (P.L. 109–171)
 D–SNP: Medicare Advantage special needs plan for individuals who are eligible for Medicare and Medicaid
 EHR: Electronic health record
 ERISA: Employee Retirement Insurance Security Act of 1974 (P.L. 93–406)
 FFS: Fee-for-service
 FIDE–SNP: a subset of D–SNPs that must fully integrate Medicare and Medicaid benefits, including long-term care services and supports, and have a contract with the state Medicaid program among other requirements
 FMAP: Federal Medical Assistance Percentage
 FOIA: The Freedom of Information Act of 1996 (P.L. 104–231)
 FQHC: Federally qualified health center
 GAO: Government Accountability Office
 GPCI: Geographic practice cost index
 HCFAC: Health Care Fraud and Abuse Control Program
 HCPCS: Healthcare Common Procedure Coding System

HHS OIG: Office of the Inspector General of the Department of Health and Human Services
 HI: Hospital insurance; benefits of Part A of the Medicare program
 HIPAA: The Health Insurance Portability and Accountability Act of 1996 (P.L. 104–191)
 HOPD: Hospital outpatient department
 HPSA: Health professional shortage area
 IPPS: Inpatient prospective payment system
 I–SNP: Medicare Advantage special needs plan for individuals who are institutionalized
 MA: Medicare Advantage
 MAC: Medicare administrative contractor
 MCTRJCA: The Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112–96)
 MDH: Medicare dependent hospital
 MedPAC: The Medicare Payment Advisory Commission
 MEI: Medicare economic index
 MIPPA: The Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110–275)
 MMA: The Medicare Prescription Drug, Improvement and Modernization Act (P.L. 108–173)
 MMIS: Medicaid Management Information System
 MSIS: Medicaid Statistical Information System
 MVPS: Medicare volume performance standard
 NCQA: National Committee on Quality Assurance
 NDNH: National Directory of New Hires
 NPI: National provider identifier
 NPRM: Notice of proposed rulemaking
 OBRA89: The Omnibus Budget Reconciliation Act of 1989 (P.L. 101–239)
 OBRA93: The Omnibus Budget Reconciliation Act of 1993 (P.L. 103–66)
 OCSE: Federal Office of Child Support Enforcement
 OE: Improper payment outreach and education program
 OPDS: Outpatient prospective payment system
 PDE: Prescription drug event
 PI: Program integrity
 PPS: Prospective payment system
 PQRS: Physician Quality Reporting System
 QE: Qualified entity
 RAC: Recovery audit contractor
 RBRVS: Recourse-based relative value scale
 RHC: Rural health clinic
 RUC: The American Medical Association/Specialty Society Relative Value Scale Update Committee
 RVU: Relative value unit
 SAMHSA: The Substance Abuse and Mental Health Services Administration
 SGR: The Sustainable Growth Rate
 SMI: Supplementary medical insurance; benefits of Part B of the Medicare program
 SNP: Medicare Advantage special needs plan
 SSA: The Social Security Act of 1935 (P.L. 74–271)
 TIN: Tax identification number

TRHCA: The Tax Relief and Health Care Act of 2006 (P.L. 109–432)

VBM: Value-based payment modifier

VBP: Value-based performance incentive program

III. BUDGET EFFECTS OF THE BILL

INFORMATION RELATING TO UNFUNDED MANDATES

The statement of unfunded mandates from the Director of the Congressional Budget Office was not available at the time the Committee Report was submitted. Pursuant to section 423(f)(2) of the Unfunded Mandates Act of 1995 (P.L. 104–4) the statement will be published in the Congressional Record in advance of floor consideration of the Committee Bill.

COST ESTIMATE

Pursuant to paragraph 11(a) of the Rule XXVI of the Standing Rules of the Senate, a Congressional Budget Office report related to the cost of the Committee Bill must accompany this report. An estimate of the cost of the Chairman’s Mark, made available to the public on December 10, 2013, is provided. Because an updated estimate of the cost of the legislation by the Congressional Budget Office was not available at the time the report was submitted, it was impracticable to provide an estimate of the cost of the Committee Bill under paragraph 11(a) of Rule XXVI of the Standing Rules of the Senate. An estimate of the cost of the Committee Bill will be made available.

CHANGES IN DIRECT SPENDING

Title I - Medicare Payment for Physicians' Services

102. Repealing the sustainable growth rate (SGR) and improving Medicare payment for physicians' services	8.4	12.8	11.2	10.2	10.4	11.4	13.1	14.3	16.0	16.4	53.0	124.1
103. Encouraging care management for individuals with chronic care needs	0	0	0	0	0	0	0	0	0	0	0	0
104. Ensuring accurate valuation of services under the physician fee schedule	*	-0.1	-0.2	-0.4	-0.6	-0.7	-0.7	-0.8	-0.9	-0.9	-1.3	-5.3
105. Promoting evidence-based care	0	0	0	0	0	*	*	*	*	*	0	*
106. Empowering beneficiary choices through access to information on physician services	0	0	0	0	0	0	0	0	0	0	0	0
107. Expanding claims data availability to improve care	0	0	0	0	0	0	0	0	0	0	0	0
108. Priorities and funding for quality measure development	*	*	*	*	*	*	*	*	*	*	0.1	0.1
109. Other Provisions	0	0	0	0	0	0	0	0	0	0	0	0

Title II - Extensions and Other Provisions

Subtitle A - Medicare Extensions

201. Floor on Geographic Adjustment for Physician Fee Schedule	0.3	0.4	0.4	0.3	0.4	0.4	0.4	0.4	0.5	0.5	1.7	4.0
202. Medicare Payment for Therapy Services	0.6	0.4	0.5	0.7	0.8	0.9	1.0	1.1	1.3	1.4	3.0	8.8
203. Medicare Ambulance Services	0.1	0.1	0.1	0.1	0.1	*	*	*	*	*	0.5	0.5
204. Medicare Dependent Hospital	*	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.6	1.4
205. Low-Volume Hospital	0.1	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	1.2	2.8
206. Medicare Special Needs Plans	0	0.3	0.4	0.4	0.2	0.2	0.2	0.1	0.1	0.1	1.4	2.0
207. Medicare Cost Contracts	0	0.1	0.1	*	*	*	*	*	*	*	0.2	0.2
208. Quality Measure Endorsement and Selection	*	*	*	*	0	0	0	0	0	0	0.1	0.1
209. Outreach and Assistance for Low-Income Programs	*	*	*	*	*	*	*	*	*	*	0.1	0.3

Subtitle B - Medicaid and Other Provisions

211. Qualifying Individual Program	0.7	0.8	1.0	1.2	1.4	0.9	0.4	0.3	0.2	0.2	5.2	7.1
212. Transitional Medical Assistance (TMA)	0.1	0.3	*	-0.1	*	*	*	*	0	0	0.3	0.2
213. Express Lane Eligibility	0	*	0	0	0	0	0	0	0	0	*	*
214. Pediatric Quality Measures	*	*	*	*	*	0	0	0	0	0	0	0
215. Special Diabetes Programs	*	0.3	0.3	0.3	0.3	0.3	*	*	0	0	1.2	1.5

Subtitle C - Human Services Extensions

221. Abstinence Education Grants	0	*	*	*	*	*	*	*	*	*	0.1	0.2
222. Personal Responsibility Education Program	0	*	*	*	0.1	0.1	0.1	*	*	*	0.1	0.3
223. Family-to-Family Health Information Centers	*	*	*	*	*	*	*	*	*	*	0	*
224. Health Workforce Demonstration	0	*	*	0.1	*	*	0	0	0	0	0.2	0.2

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Congressional Budget Office											December 11, 2013	
Preliminary Estimate for the SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013												
Subject to revision after review of final legislative language												
(Billions of dollars, by fiscal year)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2014- 2018	2019- 2023
Subtitle D – Other Provisions												
231. Commission on Patient Directed Health Care	0	0	0	0	0	0	0	0	0	0	0	0
232. Recovery Audit Contractors	0	*	*	*	*	*	*	*	*	*	*	0.1
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IPAB Interaction	0	0	0	0	0	*	*	*	*	*	0	*
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Total, Changes in Direct Spending Outlays	10.3	15.9	14.3	13.4	13.6	14.1	15.0	16.0	17.7	18.3	67.6	148.6
Total, Changes in Unified-Budget Direct Spending	10.3	15.9	14.3	13.4	13.6	14.1	15.0	16.0	17.7	18.3	67.6	148.6
<hr/>												
Memorandum												
Non-scoreable Effects (non-add)												
232. Recovery audit contractors	0	*	*	*	*	*	*	*	*	*	*	-0.1

Source: Congressional Budget Office.

Notes: Components may not sum to totals because of rounding.

* = changes in direct spending that are between \$50 million and -\$50 million.

All Medicare provisions include interactions with Medicare Advantage payments, the effect on Medicare Part A and B premiums, and TRICARE.

IPAB = Independent Payment Advisory Board; TRICARE = the health plan operated by the Department of Defense

ADDITIONAL CLARIFICATIONS PROVIDED BY THE STAFF OF THE SENATE FINANCE COMMITTEE

ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS

- There is a discrepancy between the Chairman's Mark and the legislative text of S. 1871, the SGR Repeal and Medicare Beneficiary Access Improvement Act. Page 27 of the Chairman's Mark states that applicable providers eligible to receive payments for chronic care management include doctors of medicine and osteopathy, doctors of dental surgery and dental medicine, doctors of podiatry and optometry, and chiropractors. This was arrived at by inadvertently listing all of the health care professionals defined in section 1861(r) of the SSA. However, the correct citation is section 1861(r)(1), and that mistake was corrected in the legislative text, which references section 1861(r)(1). The legislative text is correct in defining those physician types that are eligible to receive payments for chronic care management as doctors of medicine and osteopathy because those are the two categories of professionals who can provide these services contemplated in the provision.

The legislative text contains the correct definition of applicable providers eligible to receive chronic care management payments. In addition to doctors of medicine and osteopathy, the legislation specifies that nurse practitioners, clinical nurse specialists, and physician assistants are also applicable providers. Professionals receiving chronic care management payments would be accountable for coordinating a patient's care across the spectrum of health care settings. For this reason, the legislation specifies that only one provider can receive this payment for a given patient. Additionally, providers would have to practice in a patient-centered medical home or comparable specialty practice to receive the payment.

REQUIRING STATE LICENSURE OF BIDDING ENTITIES UNDER THE COMPETITIVE ACQUISITION PROGRAM FOR CERTAIN DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

- An amendment submitted by Senator Roberts and Senator Thune was modified, accepted, and reflected in the Committee Bill as section 247.

IV. VOTES OF THE COMMITTEE

In compliance with paragraph 7(b) of Rule XXVI of the Standing Rules of the Senate, the Committee states that, with a majority and quorum present, the "SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013" was amended and ordered favorably reported as follows:

The Committee on Finance met on December 12, 2013 to consider an original bill entitled, "SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013."

The Chairman's Mark was modified and amended as follows:

Amendment 8, Wyden/Isakson 1

The Better Care, Lower Cost Delivery System for Medicare Beneficiaries with Multiple Chronic Conditions.

Amendment withdrawn.

Amendment 89, Roberts/Casey 1
Expansion of MTM Targeted Beneficiary.
Amendment withdrawn.

Amendment 119, Thune/Enzi 3
Requiring Interoperability in the Meaningful Use Program by 2017.
Amendment withdrawn.

Amendment 45, Menendez/Brown 9
To make the Family-to-Family Health Information Centers and the Maternal, Infant and Early Childhood Visitation program permanent.
Amendment withdrawn.

Amendment 126, Isakson 1
Demonstration Project to Test Physician Private Contracting in Medicare.
Amendment withdrawn.

Amendment 49, Carper/Toomey/Brown 4
Improvements to Medicare Procedures to Prevent Fraudulent Diversion and Medically Unnecessary or Unsafe Use of Prescription Drugs.
Amendment withdrawn.

Amendment 32, Nelson/Schumer/Stabenow/Menendez/Casey 1
Residency Physician Shortage Reduction.
Amendment withdrawn.

Amendment 56, Cardin/Portman 4
To encourage the use of efficient dispensing techniques for long-term care pharmacies.
Amendment withdrawn.

Amendment 105, Cornyn 1
Protect seniors from a board of 15 bureaucrats empowered to make substantial changes to the Medicare without full transparency and accountability.
Amendment withdrawn.

Amendment 61, Bennet/Cornyn/Isakson 1
To incentivize states to achieve reductions in future health care cost growth while improving quality.
Amendment withdrawn.

Amendment 135, Toomey/Carper/Cornyn 1
Standard of Care Protection.
Amendment withdrawn.

Amendment 67, Casey/Rockefeller/Brown/Wyden 1
Performance Bonus Payment to Offset Additional Medicaid and CHIP Enrollment Costs Resulting from Enrollment and Retention Efforts.
Amendment withdrawn.

Amendment 99, Enzi 3
An amendment to require the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) to seek public comment on whether proposed Medicare payment policies will increase or decrease the consolidation of health care providers.
Amendment withdrawn.

Amendment 74, Grassley/Bennett/Toomey/Nelson/Portman/Rockefeller/Casey/Brown/Cantwell 5

Coordinated Care for Medically Complex Children.

Amendment withdrawn.

Amendment 102, Enzi 6

An amendment to modernize the Medicare benefit through bipartisan, common-sense reforms.

Amendment withdrawn.

Amendment 10, Wyden/Isakson/Carper/Grassley 3

An Amendment to Improve Medicare Advantage Risk Adjustment.

Amendment withdrawn.

Amendment 16, Wyden/Portman/Carper/Enzi 9

An Amendment to Include S. 1228: Medicare Better Health Rewards Program Act of 2013.

Amendment withdrawn.

Amendment 132, Portman/Brown/Stabenow 1

Health Coverage Tax Credit Extension.

Amendment withdrawn.

Amendment 26, Stabenow/Casey 2

To clarify payments for drugs under Medicare Part B by excluding prompt pay discounts from Average Sales Price.

Amendment withdrawn.

Amendment 90, Roberts/Enzi 2

Clarification of 96 Hour Rule for Critical Access Hospital Conditions of Participation.

Amendment withdrawn.

Amendment 66, Bennet/Cornyn 6

To better inform taxpayers about their individual Medicare contributions and benefits by including information in a yearly statement they already receive about Social Security.

Amendment withdrawn.

Amendment 134, Portman 3

Amendment to Improve Coordination in Behavioral Health Information Technology.

Amendment withdrawn.

Amendment 27, Stabenow 3

To postpone the rebasing of home health payments to allow for further evaluation.

Amendment withdrawn.

Amendment 129, Isakson 4

Strike Extension of Health Workforce Demonstration Project.

Amendment withdrawn.

Amendment 137, Toomey/Casey 3

Preserving Access to Orphan Drugs.

Amendment withdrawn.

Amendment 52, Carper/Grassley 7

Increasing Patient Medication Education and Adherence.

Amendment withdrawn.

Amendment 70, Grassley/Wyden 1

Transition to Independence Medicaid Demonstration.

Amendment withdrawn.

Amendment 79, Grassley/Rockefeller/Carper 10
Prevention of Diabetes Amendment.
Amendment withdrawn.

Amendment 69, Casey/Crapo 3
Delay of CMS CY14 HOPPS Final Rule Implementation of Skin
Substitute Bundling for Advanced Therapeutic Wound Healing
Products.
Amendment withdrawn.

Amendment 25, Stabenow/Grassley 1
To improve quality, and expand access to community mental health
services.
Approved by voice vote.

Amendment 18, Schumer/Grassley 1
Rural Hospital Access Act.
Approved by unanimous voice vote.

Amendment 118, Thune/Casey/Enzi 2
To provide a demonstration project on remote patient monitoring
(RPM) in the Medicare program to ensure seniors can remain in
their homes longer and to prevent hospital readmissions.
Approved by unanimous voice vote.

Amendment 82, Grassley 13
Full GPCI Permanence.
Approved by unanimous voice vote.

Amendment 4, Rockefeller/Brown/Casey 4
Transitional Medical Assistance Substitution and Improvement.
Approved by voice vote.

Amendment 21, Schumer/Grassley/Cardin/Stabenow 4
Helping Ensure Life- and Limb-Saving Access to Podiatric Physi-
cians (HELLPP) Act.
Approved by voice vote.

Amendment 120, Thune/Rockefeller 4
Providing Additional Technical Assistance to Small Rural Practices
in the Value Based Performance (VBP) Program
Approved by unanimous voice vote.

The Chairman's Mark, as amended, was ordered favorably reported
by a voice vote.

V. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In the opinion of the Committee, in order to expedite the busi-
ness of the Senate, it is necessary to dispense with the require-
ments of paragraph 12 of Rule XXVI of the Standing Rules of the
Senate (relating to the showing of changes in existing law made by
the bill as reported by the Committee).