

**Summary of HR 2: Medicare Access and CHIP Reauthorization Act of 2015**  
**As passed by the House of Representatives on March 26, 2015**

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## **Title I—SGR Repeal and Medicare Provider Payment Modernization**

### **Sec. 101. Repealing the Sustainable Growth Rate (SGR) and Improving Medicare Payment for Physicians' Services**

#### Stabilizing Fee Updates

Repeals the SGR payment methodology and provides for 0.5 percent updates for July through December 2015 and for 2016 through 2019, and then zero percent updates for 2020 through 2025. After 2025, there will be two separate conversion factors, the qualifying alternative payment model (APM) conversion factor and the nonqualifying APM conversion factor, and

updates will be 0.75 percent for qualifying APM participants and 0.25 percent for others. (APMs are defined below.)

Requires the Medicare Payment Advisory Commission (MedPAC) to submit an initial report to Congress, not later than July 1, 2017, on the relationship between utilization and expenditures (and their rates of increase) under the Medicare physician fee schedule and total utilization and expenditures (and their rates of increase) under Medicare Parts A, B, and D. This report must include a methodology to describe the relationship and the impact of changes in service ordering patterns. Requires a final report on these matters, not later than July 1, 2021. Also requires MedPAC to submit a report not later than July 1, 2019 on the effect of Medicare physician fee schedule updates for 2015 through 2019 and recommendations for future payment updates to ensure adequate beneficiary access to care.

### Consolidation of Certain Current Law Performance Programs with New Merit-Based Incentive Payment System

Sunsets separate Physician Quality Reporting System (PQRS) and Electronic Health Record (EHR) meaningful use payment adjustments, and application of the value-based modifier (VM) to physicians, after 2018. However, specifies that PQRS, EHR meaningful use and the VM programs will continue to apply after that time for purposes of the new Merit-Based Incentive Payment System (MIPS). In addition, for eligible professionals (EPs) who are not MIPS eligible in a year, provides that PQRS would remain available for such EPs who voluntarily report performance data. Does not modify section 1848(p)(7) of the Social Security Act, which is where the Secretary is granted authority to apply the VM to non-physicians (but not required to do so).

### Merit-Based Incentive Payment System

Adds a new subsection 1848(q) establishing a Merit-Based Incentive Payment System (MIPS). Provides variable, performance-based incentive payments under a new merit-based incentive payment system (MIPS) beginning January 1, 2019, based on 4 performance categories: quality, resource use, clinical practice improvement activities, and meaningful use of EHRs. Specifies that, in a year, a negative MIPS payment adjustment to the otherwise payable amounts under the Medicare physician fee schedule may not exceed a specified percent (4, 5, 7 and 9 percent for 2019, 2020, 2021, and 2022 and subsequent years, respectively). Maximum upward payment adjustments under MIPS (prior to application of a scaling factor; see below) would also be based on the applicable percentage for the year in question. However, a scaling factor of no more than 3.0 could be applied to keep incentive payments budget neutral (if this is necessary and budget neutrality can be achieved in this way; see below); for example, by using the scaling factor, maximum upward payment adjustments could exceed the applicable percentage if required to maintain budget neutrality (that is, where payment reductions under MIPS would otherwise exceed payment increases). In any case, budget neutrality would not apply if all MIPS EPs score below the performance threshold for the year, and it would also be waived if application of the maximum scaling factor had not achieved a budget neutral result.

Not later than 30 days prior to January 1 of a year, MIPS EPs must be informed of the MIPS adjustment factor (and, as applicable, the additional MIPS adjustment factor) that will apply to them in the coming year.

Also provides an additional funding pool of \$500 million per year for 2019 through 2024 to reward exceptional performance through an additional MIPS adjustment factor. The threshold for awarding these additional amounts could be set at either the 25th percentile of the range of possible composite performance scores above the applicable performance threshold or at the 25th percentile of the actual composite performance scores at or above the performance threshold for a prior period. Specifies that the resulting MIPS additional adjustment factor for a qualifying EP may not exceed 10 percent.

For 2019-2020, MIPS EPs are restricted to all Medicare physicians, and physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. For 2021 and beyond, the program also applies to other EPs (as defined in section 1848(k)(3)(B)) as specified by the Secretary. Excludes a qualifying APM participant (defined below), or a partial qualifying APM participant (also defined below) who does not report measure data required under MIPS (a partial qualifying APM participant who reports measure data is included). Also excludes an EP who does not exceed the low-volume threshold selected by the Secretary, which may include one or more or a combination of the following: a minimum number of treated Medicare beneficiaries, a minimum number of items and services furnished to such beneficiaries, or a minimum amount of Medicare Part B allowed charges billed. In addition, a professional who first becomes a Medicare-enrolled EP during the performance period for a year is not considered MIPS eligible until the subsequent year and performance period for such subsequent year.

Defines “partial qualifying APM participant” as an EP participating in an APM who meets somewhat lower payment thresholds than those for a qualifying APM participant (those APM participant thresholds are shown below). For 2019-2020, this means at least 20% of Medicare payments. For 2021-2022, this means at least 40% of Medicare payments or at least 40% of total payments (with at least 20% of Medicare payments). For 2023 and beyond, this means at least 50% of Medicare payments or at least 50% of total payments (with at least 20% of Medicare payments).

Requires the Secretary to establish a process for assessing performance on quality measures at the physician group level and the Secretary may do the same for other performance categories. Also requires the Secretary to encourage the use of qualified clinical data registries under MIPS.

Directs the Secretary to use a variety of information to assess appropriate adjustments to quality, resource and other MIPS measures, and to assess and implement appropriate adjustments to payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under MIPS.

Measures for the performance categories would generally come from measures applicable under existing PQRS, VM and EHR meaningful use programs. Directs the Secretary to emphasize outcome measures, and permits use of quality measures used in non-physician payment systems and global (e.g., population-based) quality measures. Also, in terms of measures from non-

physician payment systems, precludes use of measures for hospital outpatient departments, except in the case of emergency physicians, radiologists, and anesthesiologists. Directs the Secretary to also give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient, and authorizes the application of alternative MIPS measures and activities to them. For purposes of the resource use performance category, directs the Secretary to account for the cost of drugs under Part D, as feasible and applicable.

Requires annual publication of the list of quality measures not later than November 1 of the year prior to the start of a MIPS performance period. Mandates publication of the list of measures used by qualified clinical data registries on the CMS website. Also requires an annual call for quality measures. Before including a new or substantively changed quality measure (other than one used by a qualified clinical data registry), the Secretary must submit the measure and related supporting information for publication in applicable specialty-appropriate peer-reviewed journals. MIPS EPs reporting quality measures through EHRs would be deemed to meet quality reporting requirements under EHR meaningful use.

Defines “clinical practice improvement activity” as an activity that relevant EP organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes. Requires clinical practice improvement activities to include “at least” the following 6 subcategories: expanded access (e.g., same day appointments); population management (e.g., participation in a qualified clinical data registry); care coordination (e.g., use of remote monitoring or telehealth); beneficiary engagement (e.g., use of shared decision-making); patient safety and practice assessment (e.g., use of surgical checklists); and APM participation. In establishing activities, directs the Secretary to give consideration to practices consisting of 15 or fewer professionals, and practices located in rural and health professional shortage areas. Requires the Secretary to solicit recommendations for additional clinical practice improvement activities (and related criteria) and permits the Secretary to contract with entities to assist in identifying such activities and determining whether an EP meets the applicable criteria.

Directs the Secretary to establish performance standards for measures and activities, taking into account historical performance standards, improvement rates, and the opportunity for continued improvement. For this purpose, performance thresholds must be set at the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS EPs with respect to a prior period specified by the Secretary (the use of the mean or median may be reassessed by the Secretary every 3 years). Includes a special rule for the initial two years of the MIPS program under which performance thresholds must be based on available data from a prior period with respect to performance on measures and activities incorporated into MIPS and other factors determined appropriate by the Secretary

Specifies that the performance period under MIPS must begin and end prior to the beginning of a year for which the MIPS payments will apply (no length specified), and must be as close as possible to such year.

Specifies use of a composite scoring methodology (using a scoring scale of 0-100) with weights assigned to each performance category and each underlying measure or clinical practice

improvement activity (with a continuous distribution of performance scores, resulting in differential payments). Specifies a weight of 30% for the quality performance category (and notes that multiple-payer quality data may be included in the analysis), 30% for the resource use performance category (except for year 1 and 2 of the program when such weight must be 10 and 15 percent, respectively, with commensurate increases in the weight for quality to 50 percent and 45 percent in years 1 and 2, respectively), 15% for the clinical practice improvement performance category, and 25% for the EHR meaningful use performance category. If EHR adoption reaches 75%, the weight for the EHR meaningful use performance category may be reduced to as low as 15%, with compensating adjustments made to other category weights. The Secretary is authorized to adjust the weighting for performance categories, measures and activities if there are not sufficient measures and clinical practice improvement activities applicable and available to each type of eligible professional.

An EP failing to report relevant measure/activity data would receive the lowest potential score applicable to the measure/activity. An EP in a practice certified as a patient-centered medical home or comparable specialty practice would receive the highest potential score for the clinical practice improvement performance category, and an APM participating professional would receive at least one-half of the highest potential score for such performance category. Makes clear that an EP need not perform clinical improvement activities in each subcategory to achieve the highest potential score for the clinical practice improvement performance category. Beginning with the second year of MIPS, the scoring methodology must account for improvement with respect to quality and resource use (as well as achievement), and may do so for other performance categories. Specifies that the Secretary may assign a higher scoring weight to achievement.

Provides for voluntary virtual groups, comprised of an EP or a group practice consisting of not more than 10 MIPS EPs and at least one other such individual EP or group practice, under which performance assessment for quality and resource use would be done at the virtual group level.

Directs the Secretary to make publicly available on the Physician Compare website information regarding the performance of EPs under the MIPS, including the composite score for each such professional and his or her performance with respect to each performance category. Similarly, the Secretary is directed to make publicly available the names of EPs in eligible APMs and, to the extent feasible, the names of these APMs and the performance of such models. Mandates inclusion of a warning, where appropriate, that “publicized information may not be representative of the eligible professional’s entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.” Specifies that EPs must be provided an opportunity to review and submit corrections for the information to be made public. Also directs the Secretary to periodically post aggregate information on the MIPS, including the range of composite scores, and the range of performance with respect to each performance category.

Directs the Secretary to enter into contracts with appropriate entities (such as quality improvement organizations, regional extension centers, or regional health collaboratives), to offer guidance and assistance to EPs in practices of fewer than 15 professionals (with priority given to practices located in rural, health professional shortage and medically underserved areas and those with low composite scores) with respect to performance categories and transitioning to

an APM. Provides \$20 million for each of FYs 2016 through 2020 from the Federal Supplementary Medical Insurance Trust Fund for this purpose.

Beginning July 1, 2017, requires timely (such as quarterly) confidential feedback to EPs regarding their performance on quality and resource use measures; feedback may also address performance on clinical practice improvement and EHR meaningful use. Feedback may be accomplished through one or more mechanisms, including a web-based portal, and may involve use of data from periods prior to the current performance period. Beginning July 1, 2018, feedback must include information on services received by EPs' patients from other suppliers and providers.

Provides opportunity for informal review of an EP's MIPS adjustment factor. Precludes other administrative or judicial review of all key aspects of MIPS, including the methodology for calculating performance scores.

Requires submission of a Government Accounting Office (GAO) report by October 1, 2021 evaluating the MIPS program, including the distribution of performance and incentive payments and recommendations for improving the program. Also requires a GAO report, not later than 18 months after the date of enactment, examining the alignment of quality measures used in public and private programs, including those under Medicare Parts A, B, and C, and making recommendations on how to reduce the administrative burden involved in applying such quality measures. Requires a GAO study and report, not later January 1, 2017, on whether independent risk managers can play a role in supporting physician practices in assuming financial risk for the treatment of patients. Among other things, the report must examine barriers that small physician practices face in assuming such financial risk and any legal barriers to arrangements involving risk management entities. Finally, requires submission of a GAO report by October 1, 2021 on the transition of physicians in rural, health professional shortage and medically underserved areas to APMs, including recommendations for overcoming any barriers to such transition by such physicians, including those in small practices consisting of 15 or fewer professionals.

Transfers \$80 million from the Federal Supplementary Medical Insurance Trust Fund for each of FYs 2015 through 2019 for purposes of implementing the MIPS program.

#### Improving Quality Reporting for Composite Scores

Clarifies that reporting through qualified clinical data registries is available to EPs in a group practice reporting as a group, beginning in 2016, not just individual EPs. For reporting periods occurring in 2016 and subsequent years, allows but does not require the Secretary to provide for reporting of quality measures groups. Specifies that Quality and Resource Use Reports (QRURs) under the existing Physician Feedback Program shall not be provided to physicians after December 31, 2017 (this program would be replaced by required reports under the new MIPS). Ensures coordination between the existing EHR meaningful use requirements and the new MIPS.

#### Promoting Alternative Payment Models

Creates an 11-member Physician-Focused Payment Model Technical Advisory Committee (TAC), which will be supported by the Assistant Secretary for Planning and Evaluation and

which will review proposals for physician-focused payment models submitted by stakeholders to determine whether they meet criteria developed by the Secretary through rulemaking by not later than November 1, 2016 (following a request for information). The Secretary must respond to TAC comments and recommendations. Not more than \$5 million per year for FYs 2015 and each subsequent FY may be transferred from the Federal Supplementary Insurance Trust Fund to support the TAC and for related activities.

Adds a new subsection 1833(z) to provide incentive payments for participation in eligible APMs. For Medicare purposes, defines “alternative payment model” to include a model tested by the Center for Medicare and Medicaid Innovation or CMMI (other than a health care innovation award), an accountable care organization under the Medicare Shared Savings Program, a demonstration under the Health Care Quality Demonstration Program, and a demonstration required by Federal law. Defines an “eligible APM entity” to be an entity that participates in an APM that requires the use of certified EHR technology, provides for payment for covered professional services based on quality measures comparable to those used under MIPS, and (a) bears financial risk for monetary losses under such model that are in excess of a nominal amount or (b) is a medical home expanded under section 1115A(c), under which a model tested by the CMMI can be expanded and even applied nationwide.

For 2019 through 2024, EPs who are qualifying APM participants receive a lump sum 5% bonus payment (based on services furnished in the preceding year, which may be estimated). This is in addition to payments otherwise made under the APM. The bonus payments will not be taken into account in determining actual expenditures under the APM or in determining or rebasing related benchmarks. Bonus payments must be determined without regard to currently available bonus payments for certain primary care and general surgery services.

Defines “qualifying APM participant” to mean an EP participating in an APM who meets or exceeds certain minimum payment thresholds for Medicare and/or total payments coming through the alternative payment entity. For 2019-2020, this must be at least 25% of Medicare payments (during the most recent period for which data are available, which may be less than a full year). For 2021-2022, this must be at least 50% of Medicare payments or at least 50 percent of total payments (with at least 25% of Medicare payments). For 2023 and beyond, this must be at least 75% of Medicare payments or at least 75% of total payments (with at least 25% of Medicare payments). Payments made by the Secretaries of Defense/Veterans Affairs are not counted as part of total payments. Medicaid payments are also not counted in states in which no medical home or Medicaid APM is available. Non-Medicare payment arrangements must involve use of quality measures comparable to those used by Medicare and certified EHR technology, and the eligible professional must bear more than nominal financial risk if actual aggregate expenditures exceed expected aggregate expenditures (or be a medical home with respect to Medicaid beneficiaries). The Secretary is given authority to determine whether an EP is a qualifying APM participant by using counts of patients in lieu of using payments and using the same or similar percentage criteria as specified above.

Precludes administrative or judicial review of the determination that an EP is a qualifying APM participant and that an entity is an eligible APM entity. Also precludes administrative or judicial review of the determination of the amount of the 5 percent bonus payment.

Adds the following to the list of models to be considered for testing by the Center for Medicare and Medicaid Innovation (the Innovation Center): models focusing primarily on physicians' services furnished by physicians who are not primary care practitioners; models focusing on practices of 15 or fewer professionals; risk-based models for small physician practices, which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmission rates, and other relevant and appropriate clinical measures; and models focusing primarily on Medicaid, working in conjunction with the Center for Medicaid and CHIP Services. Specifies that effective linkage with "other public sector payers, private sector payers, or statewide payment models" instead of the existing "other public sector or private sector payers" is among the additional factors to be considered by the Innovation Center in deciding which payment models to test.

Includes language ensuring that nothing shall be construed as precluding an APM or a qualifying APM participant from furnishing telehealth services for which payment is not made under Medicare (that is, APMs and qualifying APM participants could furnish telehealth services not paid under section 1834(m)).

Mandates submission of a study by the Secretary not later than July 1, 2016 that examines the feasibility of integrating APMs into the Medicare Advantage payment system. The study must address the feasibility of including a value-based modifier and whether such modifier should be budget neutral.

Requires the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, to submit a report, not later than 2 years after the date of enactment, on the applicability of the Federal fraud prevention laws under APMs, and the vulnerability of APMs to fraudulent activity, including the implications of granted waivers, together with recommendations to reduce such vulnerability.

#### Collaborating with the Physician, Practitioner, and Other Stakeholder Communities to Improve Resource Use Management

Adds a new subsection 1848(r), which directs the Secretary to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement.

Requires the Secretary, not later than 180 days after the date of enactment, to post on the CMS website a list of episode groups developed under the episode grouper initiative and related descriptive information, provide a 120-day opportunity for public input (from physician specialty societies, applicable practitioner organizations, and other stakeholders) on additional episode groups and on patient condition groups, and post a draft list of care episode and patient condition groups and assigned codes not later than 270 days after the end of such comment period. This draft list must include care episode groups and patient condition groups that account for about one half of expenditures under Medicare Parts A and B. Directs the Secretary to then provide another 120 days for public input (other than through notice and comment rulemaking), and then post an operational list of care episode and patient condition groups and codes not later than 270 days following the end of this second opportunity for public comment. This operational list is to be revised through rulemaking by not later than November 1 of each year (beginning with 2018).

Directs the Secretary to develop patient relationship categories and codes (in order to facilitate the attribution of patients and episodes, in whole or in part, to one or more physicians or applicable practitioners) and post a draft list of such categories and codes by not later than 1 year after the date of enactment, provide a 120-day period for public input on this list, then post an operational list of patient relationship categories and codes by not later than 240 days following the end of this comment period. This operational list must be revised through rulemaking by not later than November 1 of each year (beginning with 2018). Gives as examples of patient relationships the following: (1) primary responsibility for the care of the patient over extended periods of time; (2) lead physician or practitioner furnishing items and services and coordinating care during an acute episode; (3) supportive, rather than lead, role in furnishing items and services on a continuing basis during an acute episode; (4) furnishing items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; and (5) furnishing items and services only as ordered by another physician or practitioner.

Claims submitted for items and services furnished by physicians or applicable practitioners on or after January 1, 2018, must include, as determined appropriate by the Secretary, applicable care episode, patient condition and patient relationship codes, and the national provider identifier of the ordering practitioner (if different from the billing practitioner). These codes must be used by the Secretary in evaluating the resources used to treat patients. In doing so, the Secretary must use per patient total allowed amounts for all services under Parts A and B (and D, if the Secretary determines appropriate) by care episode codes and by patient condition codes, and may use other measures of allowed amounts and utilization, taking into account input received from stakeholders through mechanisms other than notice and comment rulemaking. Precludes administrative or judicial review of the care episode, patient condition and patient relationship categories and codes, and the related resource use analyses.

For purposes of the resource use measurement program described above, defines the term “physician” to include doctors of medicine and osteopathy, and defines the term “applicable practitioner” to mean a physician assistant, nurse practitioner, or clinical nurse specialist, and beginning January 1, 2019, other EPs (as defined in subsection 1848(k)(3)(B)) as specified by the Secretary. Also specifies that the Secretary may not contract with the American Medical Association/Specialty Society Relative Value Update Committee (AMA RUC) to implement any part of this initiative, and that the Measure Applications Partnership (MAP) process does not apply to the care episode, patient condition, and patient relationship codes or the related resource use measures.

## **Sec. 102. Priorities and Funding for Measure Development**

Specifies (in new subsection 1848(s)) priorities and funding for measure development for quality measures under the MIPS and APMs<sup>1</sup>.

Directs the Secretary to, not later than January 1, 2016, develop and post on the CMS website a draft plan for the development of quality measures under the MIPS and APMs. Comments from

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<sup>1</sup>Note: With respect to APMs, the legislation specifically cites new section 1833(z)(2)(C), which describes a qualifying APM participant beginning in 2023. This appears to be an erroneous cross reference; new section 1833(z)(3)(C) provides a definition of APMs.

the public on the draft plan are to be accepted through March 31, 2016. No later than May 1, 2016 an operational plan for the development of the quality measures is to be posted, taking into account public comments on the draft plan.

Requires that the plan address the incorporation into Medicare of measures used by private payers and integrated delivery systems; describe how coordination will occur across organizations developing measures, and take into account how best practices and clinical practice guidelines should be used in developing quality measures.

Specifies considerations for the Secretary in developing the draft plan: measure gap analyses conducted by the National Quality Forum and others; whether measures are applicable across health care settings; clinical practice improvement activities submitted by stakeholders; quality domains consisting of at least 1) clinical care; 2) safety; 3) care coordination; 4) patient and caregiver experience; and 5) population health and prevention.

Prioritizes certain types of measures: outcome measures, including patient reported outcome and functional status measures; patient experience measures; care coordination measures, and measures of appropriate service use, including measures over-use.

Requires that the Secretary seek stakeholder input with respect to gaps where no quality measures exist, prioritizing measure development to address such gaps, and other areas related to quality measure development the Secretary determines to be appropriate.

Directs that the Secretary enter into contacts with entities, including organizations with expertise in quality measurement development, for the purpose of developing, improving or updating quality measures for the MIPS and APMs. Requires that priority be given to the types of measures identified above, and that in selecting measures the Secretary consider whether the measures are electronically specified and whether clinical practice guidelines exist.

Requires that an annual report on progress in developing quality measures be posted no later than May 1, 2017 and annually thereafter. Directs that the report include a description of the Secretary's efforts, information on measures developed in the prior year (the number and types of measures, a list of measure names and developers, funds expended on each measure type, and indicate which measures are electronically specified), and similar information on measures in development at the time of the report along with a timeline for completion. Any updates to the operational plan such as newly identified measure gaps are also to be included along with an inventory of measures under the MIPS and APMs.

Appropriates for the purposes of this section \$15 million for each of fiscal years 2015 through 2019, to be transferred from the Supplementary Medical Insurance Trust Fund. Amounts transferred remain available through fiscal year 2022.

The Paperwork Reduction Act does not apply to the collection of information for the development of quality measures.

### **Section 103. Encouraging Care Management for Individuals with Chronic Care Needs**

Directs the Secretary to make payment (as the Secretary determines to be appropriate) for chronic care management services furnished on or after January 1, 2015 by a physician, physician assistant, nurse practitioner, clinical nurse specialist or certified nurse midwife. Payment shall be made to only one provider for an individual for a period, shall not be duplicative, and cannot be conditioned upon the furnishing of an annual wellness visitor initial preventive physical examination. (Note: Medicare payment under a new chronic care management code began on January 1, 2015. This policy is described in the physician fee schedule final rules for 2014 and 2015 (78 FR 74414-74427 and 79 FR 67715-67730, respectively). More information on the new payment policy is available at <http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2015-02-18-Chronic-Care-Management-new.html>.)

Requires that the Secretary conduct and education an outreach campaign to inform professionals and beneficiaries of the benefits of chronic care management services; the campaign is to be directed by the HHS Office of Rural Health Policy and the CMS Office of Minority Health and to focus on encouraging participation by underserved rural populations and racial and ethnic minority populations.

Not later than December 31, 2017 the Secretary is to report to Congress on the use of chronic care management services by rural and ethnic minority populations that identifies barriers to receiving chronic care management services and makes recommendations for increasing the appropriate use of these services.

### **Sec. 104. Empowering Beneficiary Choices Through Continued Access to Information on Physicians' Services**

Beginning in 2015, requires the Secretary to annually make information publically available in an easily understood format on physicians' and other eligible professionals' items and services furnished to Medicare beneficiaries. The information would be similar to the type of information in the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File (with respect to 2012) and would be made available in a similar manner.

At a minimum the data would be required to include

- Information on the number of services furnished by the physician or other eligible professional under Part B of the Medicare program (which, for example, could include information on the most frequent services furnished or groups of services);
- Information on submitted charges and payments for such services; and
- A unique identifier for the physician or other professional that is available to the public.

Requires that the information be searchable by the specialty or type of physician or other eligible professional; characteristics of the services furnished, such as volume or groupings of services; and the location of the physician or other eligible professional.

Requires the Secretary, beginning with 2016, to integrate such information with Physician Compare.

Other eligible professionals include physician extenders, physical or occupational therapists, qualified speech-language pathologists, audiologists, as well as other providers such as certified nurse-midwives, and clinical social workers and psychologists.

### **Sec. 105. Expanding Availability of Medicare Data**

Expands the uses of Medicare data by qualified entities. (Under current law, qualified entities are public or private entities that are 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.) Beginning July 1, 2016, a qualified entity could use Medicare claims data combined with claims data from other sources to evaluate the performance of providers of services and suppliers, to conduct additional non-public analyses (as determined appropriate by the Secretary), and to provide or sell such analyses to authorized users for non-public use (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

Establishes certain limitations on the use of the data. Analyses provided or sold to an employer could only be used by the employer for purposes of providing health insurance to its employees and retirees. A qualified entity could not provide or sell an analysis to a health insurance issuer unless the issuer is providing the qualified entity with data (other than Medicare data) to combine with the Medicare claims.

Beginning July 1, 2016, allows qualified entities to provide or sell combined data to providers of services, suppliers, medical societies or hospital associations for non-public use, including for assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities, including developing new models of care. For Medicare claims data not combined with other data, the provision allows qualified providers to provide such data but they may not sell it.

Prohibits any analysis or data provided or sold from containing information that individually identifies a patient except in the case of information on patients of the provider of services or supplier itself. Prohibits authorized users from using such analyses or data for marketing purposes.

Requires qualified entities and authorized users of the data to enter into a data use agreement that describes the requirements for privacy and security of the data and, as determined appropriate by the Secretary, any prohibitions on using the data to link to other individually identifiable sources of information. If the authorized user is not a covered entity under rules implementing the Health Insurance Portability and Accountability Act, requires that the agreement identify the relevant regulations, as determined by the Secretary, that the user would comply with if it were to act in the capacity of a covered entity.

Prohibits an authorized user that is provided with an analysis from redisclosing or making public the analysis or data or any analysis using such data. Allows a provider of services or a supplier,

as determined by the Secretary, to redisclose such analysis or data for the purposes of performance improvement and care coordination activities. However, they may not make such analysis or data public nor make public any analysis using such data. Requires that, prior to a qualified entity providing or selling an analysis to an authorized user, the qualified entity provide the provider or supplier with the opportunity to appeal and correct errors.

Provides for an assessment on qualified entities in the case of a breach of a data use agreement whether such agreements are between the Secretary and a qualified entity or between a qualified entity and an authorized user. In such cases, the Secretary is required to assess up to \$100 for each individual entitled to or enrolled in Medicare Part A or Part B benefits. Any amounts collected would be deposited in Federal Supplementary Medical Insurance Trust Fund.

Requires any qualified entity that provides or sells an analysis or data to submit an annual report to the Secretary that includes (a) a summary of the analyses provided or sold, including the number of such analyses, the number of purchasers of such analyses, and the total amount of fees received for such analyses; (b) a description of the topics and purposes of such analyses; (c) information on the entities who received the data, the uses of the data, and the total amount of fees received for providing, selling, or sharing the data; and (d) other information determined appropriate by the Secretary.

Beginning on July 1, 2016, requires the Secretary to provide, upon request, Medicare claims data and, as the Secretary determines appropriate, Medicaid and CHIP claims data, to qualified clinical data registries. These data would be provided for the purpose of linking with clinical outcomes data and for performing analyses and research in support of quality improvement and patient safety activities. Requires that these data be provided at a fee equal to the cost of providing such data. Further requires that any public reporting of these analyses or research that identifies a provider gives the provider an opportunity to appeal and correct errors.

Beginning on July 1, 2016, expands the types of data that the Secretary may make available to qualified entities to include standardized extracts (as determined by the Secretary) of Medicaid and CHIP claims data.

Starting on July 1, 2016, revises the account that fees collected for providing data are deposited into. Instead of placing such fees into the Federal SMI trust fund, such fees will be deposited into the Centers for Medicare and Medicaid Services Program Management Account.

## **Section 106. Reducing Administrative Burden and Other Provisions**

### Medicare private contracting

Under existing private contracting provisions, physicians and certain practitioners can enter into private contracts with Medicare Part B beneficiaries, under which they may bill patients for services without being subject to the upper payment limits specified by Medicare. A physician/practitioner with such an agreement foregoes any reimbursement by Medicare for all Medicare beneficiaries for 2 years, except that Medicare will pay for emergency or urgent care services provided to a beneficiary with whom the physician/practitioner does not have private contract.

Requirements for physician and practitioner private contracting are amended to provide for automatic continuation of 2-year “opt-out” periods until the physician or practitioner notifies CMS, which must be no later than 30 days before the end of a 2-year period. The change in policy is effective for opt-out affidavits signed beginning 60 days after the date of enactment.

Directs the Secretary to post by February 1, 2016 (and update annually) public information on an HHS website regarding physicians and practitioners who have elected the private contracting option (i.e., those who are opting out.). The website information is to include the number of these physicians and practitioners, their physician or professional specialty, the geographic distribution, the length of time for which they have been opt-out physicians and practitioners, and the proportion who have billed Medicare for emergency or urgent care services.

### Interoperability of Electronic Health Record Systems

Makes a declaration of Congress that it is a national objective to achieve widespread exchange of health information through interoperable certified EHR technology nationwide by December 31, 2018. Directs the Secretary, in consultation with stakeholders, to establish metrics no later than July 1, 2016, for use in determining whether the objective has been achieved. If the Secretary determines that the objective has not been achieved by December 31, 2018, a report must be submitted to Congress by December 31, 2019 identifying barriers to achieving the objective and recommending federal actions. Such recommended actions may include adjusting payments under the Medicare EHR incentive program for not being meaningful EHR users, and criteria for decertifying EHR technology products.

Effective one year after the date of enactment, amends meaningful use requirements regarding information exchange to require that the professional (or hospital) demonstrate through a process specified by the Secretary, such as attestation, that the professional (or hospital) has not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of the certified EHR technology.

Requires the Secretary to study the feasibility of establishing one or more mechanisms to assist providers in comparing and selecting certified EHR technology products. These may include a website providing survey results from meaningful users comparing products and standardized information from vendors. Survey results may be obtained by contract with organizations that maintain such information. Report on these mechanisms is due within one year of enactment.

### GAO Studies on Telehealth and Remote Patient Monitoring

Directs GAO to study telehealth and remote patient monitoring services and report within 24 months of enactment. Reports may be issued together or separately.

- Telehealth study to include how the definition of telehealth across federal programs can inform Medicare telehealth policy; issues that can facilitate or inhibit the use of telehealth under the Medicare program, such as oversight and professional licensure, changing technology, privacy and security, infrastructure requirements and varying needs across urban and rural areas; potential implications of greater use of telehealth with respect to

payment and delivery transformations; and how CMS monitors Medicare payments made for telehealth services.

- Remote patient monitoring study to include the dissemination of remote patient monitoring technology in the private insurance market; financial incentives in the private insurance market for adoption of this technology; barriers to Medicare program adoption; evaluation of patients, conditions and circumstances that could benefit from remote patient monitoring services; and evaluation of challenges in establishing appropriate valuation of remote patient monitoring under the physician fee schedule.

#### Rule of Construction Related to Health Care Providers and Liability

Provides that the development, recognition, or implementation of any guideline or other standard under any provision of the Patient Protection and Affordable Care Act, the Health Care Education Reconciliation Act, Medicare or Medicaid shall not be construed to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim. Nothing in the rule of construction or the laws cited above are to be construed as pre-empting state or common law governing medical professional or medical product liability actions or claims.

### **TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS**

#### **Subtitle A—Medicare Extenders**

##### **Sec. 201. Extension of Work GPCI Floor**

Extends the work geographic practice cost index (GPCI) floor of 1.00 through December 31, 2017.

##### **Sec. 202. Extension of Therapy Cap Exceptions Process**

Extends the therapy cap exceptions process through December 31, 2017. Replaces the manual medical review process for therapy cap exceptions with a new medical review process in which the Secretary determines which therapy services to review considering such factors as a therapy provider who (i) has had a high claims denial percentage or is less compliant with applicable Medicare program requirements; (ii) has a pattern of billing for therapy services that is aberrant compared to peers or otherwise has questionable billing practices, such as billing medically unlikely units of services in a day; (iii) is newly enrolled or has not previously furnished therapy services under the Medicare program; (iv) provides services to treat a type of medical condition; or (v) is part of a group that includes another therapy provider identified by the above factors. The new medical review process applies to exceptions requests for which a medical review has not been conducted by a date (not later than 90 days after enactment) specified by the Secretary.

Provides \$5 million from the Federal Supplementary Medical Insurance (Medicare Part B) Trust Fund for fiscal years 2015 and 2016, to remain available until expended, to implement the new medical review process. The funds cannot be used by a Medicare recovery audit contractor (RAC) for medical reviews of therapy services.

### **Sec. 203. Extension of ambulance add-ons**

Extends the temporary super rural, rural and urban add-ons to Medicare's ambulance fee schedule for ground ambulance payments through December 31, 2017.

### **Sec. 204. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals**

Extends the current low-volume hospital payment adjustment through December 31, 2017.

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

Extends the current Medicare-Dependent Hospital Program through September 30, 2017. Hospitals may continue to decline re-classification.

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

Extends the Medicare Advantage Plan option for special needs individuals through the end of CY 2018.

### **Sec. 207. Extension of funding for quality measure endorsement, input, and selection**

Transfers \$30 million for each fiscal year, FY 2015 through FY 2017, from the Medicare Trust Funds to provide continued funding for the National Quality Forum, the Measure Applications Partnership and related activities, with the funds remaining available until expended.

### **Sec. 208. Extension of funding outreach and assistance for low-income programs**

Extends funding for low-income outreach and assistance activities, as follows: State Health Insurance Counseling and Assistance Programs, \$7.5 million for FY 2015, \$13 million for FY 2016 and \$13 million for FY 2017; Area Agencies on Aging, \$7.5 million for FY 2015, \$7.5 million for FY 2016 and \$7.5 million for FY 2017; Aging and Disability Resource Centers, \$5 million for FY 2015, \$5 million for FY 2016 and \$5 million for FY 2017; and the National Center for Benefits and Outreach Enrollment, \$5 million for FY 2015, \$12 million for FY 2016 and \$12 million for FY 2017.

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

Transitions reasonable cost plans that can no longer qualify to be cost plans under current statutory requirements into Medicare Advantage (MA) plans and allows cost plans that would otherwise qualify under the statutory requirement, to voluntarily transition into MA plans. [Under current law, after January 1, 2016 the Secretary cannot extend or renew a cost contract for a service area if (1) during the entire previous year there were either two or more Medicare Advantage (MA) regional plans or two or more MA local plans in the service area offered by different MA organizations, and (2) these regional or local plans meet specified minimum enrollment requirements.] Establishes these provisions for plans so affected:

- i. The cost contract may be extended for the two years subsequent to 2016. The contract's final year is referred to as the "last reasonable cost reimbursement contract year for the contract" or the "last year".
- ii. The organization cannot enroll a new enrollee during the last year, but may continue to enroll new enrollees through the end of the previous year unless the enrollee is one of the following:
  - An individual who chooses enrollment in the reasonable cost contract during the annual election period for such last year;
  - An individual whose spouse is an enrollee under the cost contract;
  - An individual who is covered under an employer group health plan that offers coverage through the cost contract; or
  - An individual who becomes entitled to benefits under part A, or enrolled under part B, and who just prior to Medicare eligibility is enrolled in a non-Medicare plan offered by the organization.
- iii. Requires the organization offering the cost plan to notify the Secretary whether or not the contract is to be converted, in whole or in part, to an MA plan for the year following the last year.
- iv. Requires organizations converting the cost contract, in whole or in part, to an MA plan to provide the Secretary with information necessary to carry out the deeming enrollment process in section 1851(c)(4) and the bidding review process used to determine MA payments in section 1854(a)(5).
- v. Requires cost plans enrolling a beneficiary during the last year to notify the individual that it is the last year for the contract.

During the last year and the year prior to the last year, permits the organization or its corporate parent organization to offer an MA plan in the same area and to enroll beneficiaries in both the MA plan and the cost plan.

Applies deemed enrollment under section 1851(c)(4) and the special rule for quality increase under section 1853(o)(4)(C) to cost contracts converting, in whole or in part, to an MA plan. Absent election otherwise, a beneficiary who was enrolled in a cost plan during the last year of a reasonable cost contract is deemed to elect to receive benefits through an applicable MA plan if these provisions apply:

- i. The beneficiary was enrolled in the reasonable cost plan in the previous year, and the plan was extended or renewed for the last year;
- ii. The cost plan provided notice to enrollees that it was to be converted to an MA plan;
- iii. The applicable MA plan is the plan that was converted from the cost plan and is offered by the same entity or organization that had previously entered into the cost contract, and in the same service area where the beneficiary resides;
- iv. The difference in the premiums and other costs determined by the Secretary for both the cost plan and the subsequent MA plan does not exceed a threshold established by the Secretary;
- v. For enrollees transitioning from the cost contract, the subsequent MA plan maintains networks of providers and suppliers and courses of treatment for beneficiaries currently in care for at least 90 days after the conversion;

- vi. During the 90-day transition, the MA plan pays providers and suppliers amounts that are not less than what is paid under original Medicare.

Beneficiaries who are eligible for the deemed enrollment process and who are not enrolled in a prescription drug plan under Part D are enrolled in a MA plan without a Part D drug benefit. Beneficiaries with Part D drug coverage through the cost contract or through a Part D plan sponsored by the same entity (or an organization affiliated with such entity) are enrolled in a MA plan with Part D coverage.

Requires the Secretary to identify and notify enrollees affected by the deemed enrollment process no later than 45 days before the first day of the annual, coordinated election period for the plan year beginning on or after January 1, 2017.

For beneficiaries with deemed enrollment in a newly converted MA plan or MA-PD plan, there is a special election period running from after the last day of the annual coordinated election period until the end of February of the first plan year for which the beneficiary is enrolled in the MA plan. Such a beneficiary may change plan selection, including changing the MA plan or MA-PD plan in which the individual is enrolled. A beneficiary can only exercise this option once. A beneficiary developing end-stage renal disease while enrolled in a cost contract which converts to an MA contract also is eligible for deemed enrollment.

Requires an MA organization offering a newly converted MA plan to provide affected enrollees with the following information not later than 30 days prior to the first day of the annual coordinated election period:

- i. Notification that the individual is deemed to have made an election to receive benefits under an MA plan or an MA-PD plan for the next plan year, but that the individual may make a different election during the annual, coordinated election period;
- ii. The information that the Secretary is required to send to all beneficiaries prior to the beginning of the annual, coordinated election period;
- iii. A description of the differences between the MA or MA-PD plan and the reasonable cost plan in which the individual was recently enrolled, including information on benefits, cost-sharing, premiums, drug coverage, and provider networks;
- iv. Information about special election periods; and
- v. Other information the Secretary may specify.

For the first three years after a cost plan converts to an MA plan, any quality adjustments applied to the newly converted plan's MA benchmark are not treated as a new MA plan. To the extent that MA data for a plan are not available for a measure used to determine the star rating, the Secretary is to use data from a period during which the plan was under a reasonable cost contract.

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

Extends through December 31, 2017 the three percent add-on to payments made under the home health prospective payment system (HH PPS) for home health services provided to patients in rural areas.

## **Subtitle B—Other Health Extenders**

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

Extends the QI program permanently and appropriates \$535 million for the remainder of 2015 (April 1, 2015 to December 31, 2015) and \$980 million for 2016 and subsequent years, subject to adjustment. Authorizes the Secretary to increase the allocation amount for years after 2016 up to an amount that does not exceed the product of the following: (1) for 2017, the allocation amount for 2016, and for subsequent years, the maximum allowable allocation amount for the previous year; (2) one plus the percentage increase from the previous year in the Medicare Part B premium; and (3) one plus the percentage increase from the previous year in the average number of individuals enrolled under Part B as estimated by the CMS Actuary.

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

Permanently extends Section 1925 work-related TMA, requiring states to provide at least 6, and up to 12, months of TMA coverage to families losing Section 1931 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.

### **Sec. 213. Extension of special diabetes program for type I diabetes and for Indians**

Extends funding for two diabetes-related programs within the Public Health Service, the Type I Diabetes and Type II Indian Health Service programs, through December 31, 2017.

### **Sec. 214. Extension of abstinence education**

Increases and extends funding for Section 510 Abstinence Education grants to \$75 million for each of fiscal years 2016 and 2017. Directs that the budget baseline is to be calculated assuming that no grant is made under Section 510 after FY 2017. Provides for reallocation of unused funding to other states.

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

Extends the authorization and funding for the section 513 Personal Responsibility Education Program through FY 2017 at \$75 million per year.

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

Extends funding for the Family-to-Family Health Information Centers program, which makes grants to family-staffed organizations providing health care information and resources to families of children with special health care needs. Provides full year funding of \$5 million for FY 2015 (previously funded at \$2.5 million through March 31, 2015) and provides \$5 million for each of FY 2016 and FY 2017.

### **Sec. 217. Extension of health workforce demonstration project for low-income Individuals**

Extends through FY 2017 (with annual funding at \$85 million) the health professions opportunity grant program (HPOG), which helps individuals obtain education and training in health care jobs that pay well and are in high demand.

### **Sec. 218. Extension of maternal, infant, and early childhood home visiting programs**

Extends through all of FY 2015 (October 1, 2014 through September 30, 2015) the \$400 million made available under the Protecting Access to Medicare Act (PAMA, P.L. 113-93) for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and provides \$400 million for each of FY 2016 and FY 2017. This program provides states, territories, and tribes with grants to support evidence-based early childhood home visiting programs for at-risk families.

### **Sec. 219. Tennessee DSH allotment for fiscal years 2015 through 2025**

Provides a Medicaid DSH allotment to Tennessee in the amount of \$53.1 million for each fiscal year from FY 2015 through FY 2025. Under current law, Tennessee is the only state without a Medicaid DSH allotment for FY 2014 and subsequent years.

### **Sec. 220. Delay in effective date for Medicaid amendments relating to beneficiary liability settlements**

When another insurer or payer has financial responsibility for medical services provided to Medicaid beneficiaries, third-party liability (TPL) rules generally require the third party to pay all or part of the bill before Medicaid pays. Federal Medicaid TPL law requires states to recover from judgments awarded to Medicaid beneficiaries. Recent court cases limited states' ability to recover from judgments. In those cases, states were restricted to collecting only from the medical care costs portion of the judgement rather than from the entire settlement, or from the settlement amounts for lost wages or non-medical costs. Section 202, Strengthening Medicaid Third-Party Liability, of the Bipartisan Budget Act of 2013 (P.L. 113-67), effective October 1, 2014, enabled states to recover from all portions of judgments received by Medicaid beneficiaries. Section 202 also clarified that states may impose liens against Medicaid beneficiaries' property. Section 211 of PAMA delayed the effective date of the beneficiary liability settlement amendment from October 1, 2014, until October 1, 2016 and this legislation further delays the effective date of the beneficiary liability settlements provision from October 1, 2016, until October 1, 2017.

### **Sec. 221. Extension of funding for community health centers, the National Health Service Corps, and teaching health centers**

Provides funding for Community Health Center Fund (CHCF) health centers and the National Health Service Corps (NHSC) at the FY 2015 level (\$3.6 billion for health centers and \$310 million for the NHSC) for each of FY 2016 and FY 2017. Provides \$60 million for each of FY 2016 and FY 2017 to support direct and indirect GME payments to teaching health centers. Applies an existing abortion restriction on the use of funds appropriated by this act to health centers, the NHSC, and qualified teaching health centers for FY 2016 and FY 2017. The

restriction also was included in P.L. 113-235, Division G, Title V, Sections 506-507, which provided appropriations for FY 2015.

### **Title III – CHIP**

#### **Sec. 301. 2-Year Extension of the Children’s Health Insurance Program**

Extends funding for state allotments under the Children’s Health Insurance Program for two more fiscal years: 2016 and 2017. Provides \$19.3 billion for state allotments for fiscal year 2016. For fiscal year 2017, provides a total of \$20.4 billion. That amount is comprised of two semi-annual appropriations of \$2.85 billion and a one-time appropriation of \$14.7 billion.

Each state’s allotments are calculated as under current law with one exception. For fiscal year 2018, any remaining funds from states’ 2017 allotments are reduced by one-third.

Enhanced federal matching payments to be calculated as established under the Affordable Care Act (ACA) for fiscal years 2016 and 2017. (The ACA provided for an increase of 23 percentage points (up to a ceiling of 100%) in the usual CHIP federal matching rate for most CHIP expenditures for the period of FY2016 through FY2019.)

#### **Sec. 302. Extension of Express Lane Eligibility**

Extends the Medicaid and CHIP Express Lane Option for two additional years through September 2017.

#### **Sec. 303. Extension of Outreach and Enrollment Program**

Extends the availability of outreach and enrollment grants designed to increase the enrollment and participation of eligible children under Medicaid and CHIP through 2017. Appropriates \$40 million for those activities for the two-year period of fiscal years 2016 and 2017.

#### **Sec. 304. Extension of Certain Programs and Demonstration Projects**

Extends the childhood obesity demonstrations by appropriating \$10 million for the period of fiscal years 2016 and 2017. In addition, extends the pediatric quality measures program through 2017 by appropriating \$20 million for the period of fiscal years 2016 and 2017.

#### **Sec. 305. Report of Inspector General of HHS on Use of Express Lane Option Under Medicaid and CHIP**

Directs the HHS Inspector General to submit to the Committee on Energy and Commerce in the House of Representatives and the Committee on Finance of the Senate a report on the Express Lane Eligibility Option. Requires the report to be submitted no later than 18 months after the date of enactment and to include data on the number of individuals enrolled in those programs through the use of the option, the extent to which those enrolled meet the eligibility requirements of those programs, and data on spending including spending disaggregated based on whether or not the individuals meet the programs’ eligibility requirements.

## **Title IV – Offsets**

### **Subtitle A – Medicare Beneficiary Reforms**

#### **Sec. 401. Limitation on Certain Medigap Policies for Newly Eligible Medicare Beneficiaries**

Prohibits the sale of a Medicare supplemental (Medigap) policy (or policy rider) that covers the Part B deductible to a newly eligible Medicare beneficiary, beginning January 1, 2020. A newly eligible beneficiary is defined as one who has neither attained age 65 before January 1, 2020 nor was entitled to or deemed eligible for Medicare through Social Security disability eligibility before that date.

Permits states that have previously received a waiver from the Medigap requirements under section 1882 of the Social Security Act (because they had alternative requirements for standardized Medigap benefits) to modify their standardized benefit structure to conform to the elimination of coverage for the Part B deductible effective January 1, 2020. (Note: The states affected by this provision are Massachusetts, Minnesota and Wisconsin.)

Effective on January 1, 2020, deems references in section 1882 to Medigap benefit packages “C” and “F”<sup>2</sup> to be references to packages “D” and “G”, respectively. (Note: Among the ten standardized Medigap benefit packages, “C” and “F” are the only ones that cover the Part B deductible. Plans “D” and “G” are identical in benefits to “C” and “F”, respectively, except for the coverage of the Part B deductible.)

Applies criminal and civil penalties that otherwise apply to Medigap requirements under section 1882(d)(3)(A) to a violation of the prohibition on Part B deductible coverage in this section. These include fines, imprisonment of up to 5 years, and civil money penalties of not to exceed \$25,000 (or \$15,000 in the case of a person other than the issuer of the policy) for each such prohibited act.

#### **Sec. 402. Income-Related Premium Adjustment for Parts B and D**

Modifies the schedule for application of the income-related premium adjustment for Parts B and D beginning in 2018. The table below shows the income thresholds and the “applicable percentage” that will apply beginning in 2018; for comparison purposes, the thresholds and amounts in effect for 2015 are also shown. (Thresholds shown are for individuals; for married couples filing a joint tax return the threshold amounts are double.) The “applicable percentage” is the share of Part B expenditures that beneficiary premiums are calculated to cover for individuals in the income category, taking into account both the standard Part B premium and the income-related premium. The standard Part B premium is calculated to cover 25 percent of Part B expenditures.

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<sup>2</sup> Section 1882(o)(5) requires that the issuer of a Medigap policy must offer at least packages “C” or “F.” Section 1882(p)(11)(A)(i) provides for the sale of a high-deductible option for plans “F” and “J.” (Sale of Plan J has been discontinued.) Section 1882(s)(3) applies certain protections for beneficiaries with prior coverage to plans “A”, “B,” “C” and “F,” and section 1882(v)(3) provides for guarantee issue of plans “A”, “B,” “C” and “F,” to certain beneficiaries enrolling in Medicare Part D who were previously covered by a Medigap plan providing prescription drug coverage.

<b>Modified Adjusted Gross Income:</b>	<b>Applicable percentage beginning in 2018</b>	<b>Applicable percentage in 2015*</b>
\$85,000 or less	25 percent (standard Part B premium only)	25 percent (standard Part B premium only)
More than \$85,000 but not more than \$107,000	35 percent	35 percent
More than \$107,000 but not more than \$133,500	50 percent	50 percent
More than \$133,500 but not more than \$160,000	65 percent	50 percent
More than 160,000 but not more than \$214,000	80 percent	65 percent
More than \$214,000	80 percent	80 percent

\*See <http://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html>

Maintains freeze on adjustments to the income-related premium income thresholds for inflation through 2019. The underlying statute provides that the income thresholds are adjusted annually to reflect changes in the Consumer Price Index for all urban consumers (for the previous year ending in August), except that such indexing is suspended for 2011 through 2019, during which time the thresholds are set to equal the thresholds in place in 2010. In 2020, the thresholds would be adjusted to reflect changes in the CPI from August 2006 to August 2019. This provision instead limits the indexing of the new thresholds in 2020 to reflect only changes in the CPI from August 2018 to August 2019. In combination with the newly defined thresholds, the result is to exclude any annual inflation adjustments that otherwise would have been applied for the years 2011 through 2019.

## **Subtitle B – Other Offsets**

### **Sec. 411. Medicare Payment Updates for Post-Acute Providers**

Sets the fiscal year 2018 payment rate update factors for skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, hospices, and long-term care hospitals to equal 1 percent.

### **Sec. 412. Delay of Reduction to DSH Allotments**

Modifies the reductions in Medicaid disproportionate share hospital (DSH) allotments to the states, which were adopted under the Affordable Care Act and subsequently modified. The initial year of reduction is delayed from 2017 to 2018, and an additional year of reduction (2025) is added. The new schedule of reductions is as follows: 2018: \$2 billion; 2019: \$3 billion; 2020: \$4 billion; 2021: \$5 billion; 2022: \$6 billion; 2023: \$7 billion; 2024 and 2025: \$8 billion each year. (These reduction amounts total \$43 billion. The previously scheduled 2017 reduction was \$1.8 billion and all reductions totaled \$35.1 billion for 2017 through 2024.)

### **Sec. 413. Levy on Delinquent Providers**

Increases the amount that the Treasury may levy on Medicare providers in order to collect delinquent tax debt under the Federal Payment Levy Program from 30% to 100% of the Medicare payment. This provision is effective 180 days after the date of enactment.

### **Sec. 414. Adjustments to Inpatient Hospital Payment Rates**

Prior law<sup>3</sup> provides for a recoupment of \$11 billion in payments to hospitals for services under inpatient prospective payment system. (The recoupment is intended to recapture the increase in aggregate IPPS payments from fiscal years 2008 through 2013 resulting from changes in coding and classification associated with implementation of the Medicare Severity Diagnosis Related Group (MS-DRG) system that did not reflect real changes in case mix and for which no payment adjustment was previously applied.) The Secretary is required to implement the \$11 billion recoupment by reducing the IPPS rates for fiscal years 2014 through 2017, and this process is underway. Currently, the recoupment is estimated to result in a cumulative 3.2 percent reduction in IPPS payments to hospitals through 2017 when the recoupment will be complete. Completion of the recoupment will have the effect of increasing the IPPS payment rates for FY 2018 by an estimated 3.2 percent. (Other update factor components will also apply in setting the IPPS rates FY 2018 (i.e., the market basket and productivity adjustments, and a 0.75 percentage point legislated reduction in the update factor.))

This provision:

- 1) replaces the (estimated 3.2 percent) one-time FY 2018 increase that will occur as a result of the completion of the recoupment with a series of six 0.5 percent rate increases covering each of fiscal years 2018 through 2023, and
- 2) removes the Secretary's authority to make an additional prospective adjustment to IPPS rates to offset payment increases resulting from documentation and coding changes for discharges occurring during fiscal year 2010. (This amount is currently estimated to be 0.55 percent.)

## **Title V – Miscellaneous**

### **Subtitle A – Protecting the Integrity of Medicare**

#### **Sec. 501. Prohibition of Inclusion of Social Security Account Numbers on Medicare Cards.**

Beginning on a date specified by the Secretary but not later than 4 years after the date of enactment of the Act, Medicare cards first issued to Medicare beneficiaries on or after that date may not display, have coded or have embedded on the card the Social Security account number (SSN) of the beneficiary or a derivative of the SSN. Any identifier displayed on the card may not be identifiable as an SSN or derivative thereof. The Secretary is also required to reissue Medicare cards without SSN identifiers (or derivatives thereof) by not later than 8 years after the date of the enactment of this Act (presumably to replace current cards with SSNs or derivatives).

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<sup>3</sup> Section 7(b) of the TMA, Abstinence Education, and QI Programs Extension act of 2007(Public Law 110-90) as amended by section 631 the American Taxpayer Relief Act of 2012 (Public Law 112-240).

The Secretary, in consultation with the Commissioner of Social Security, must implement a cost-effective procedure to comply with the mandates described above. The procedure must be done in a way that causes the least amount of disruption to beneficiaries and health care providers, for example by including such features as a toll-free number for beneficiary queries and outreach for providers. The Secretary and the Commissioner must also consider using a process similar to the Railroad Retirement Board process whereby an identifier that is not an SSN (or derivative) is used for identifying Medicare beneficiaries outside HHS which is then converted to the beneficiary's SSN for use within HHS and the Social Security Administration.

Funding: The following fiscal year (FY) transfers are made from the Medicare Trust Funds:

	<b>CMS</b>	<b>SSA</b>	<b>Railroad Retirement Board</b>
FY 2015, available through FY 2018	\$65,000,000	\$27,000,000	
FY 2015, available until expended			\$3,000,000
FY 2016, available through FY 2018	\$53,000,000	\$22,000,000	
FY 2017, available through FY 2018	\$53,000,000	\$22,000,000	
FY 2018, available until expended	\$48,000,000	\$27,000,000	

**Sec. 502. Preventing Wrongful Medicare Payments for Items and Services Furnished to Incarcerated Individuals, Individuals Not Lawfully Present, and Deceased Individuals**

The Secretary must establish procedures to ensure that no payment is made under the Medicare program for items and services furnished to an individual who is any of the following:

1. Incarcerated.
2. Not lawfully present in the United States and not eligible for Medicare coverage.
3. Deceased.

The procedures would include claims processing edits, improving provider access to eligibility information updates, and recoupment activities, including use of recovery audit contractors (RACs). While no deadline is specified in the legislation for the procedures, the HHS Office of Inspector General (OIG) must prepare periodic reports for Congress (the first one being due 18 months after enactment) on the procedures established and the activities conducted to prevent Medicare payment for claims for services furnished to those individuals.

**Sec. 503. Consideration of Measures Regarding Medicare Beneficiary Smart Cards**

Subject to certain conditions, the Secretary is required to consider smart card technologies or other electronic card technologies for use by Medicare beneficiaries and providers of services and suppliers under the Medicare program. The Secretary must determine that the use of such cards would be cost-effective and technologically viable. If the Secretary considers using the technologies, she must submit to the congressional committees with jurisdiction over the Medicare program a report outlining the considerations. There is no deadline for this provision.

## **Sec. 504. Modifying Medicare Durable Medical Equipment Face-To-Face Encounter Documentation Requirement**

Under current law, certain items of durable medical equipment may only be covered under the program for a Medicare beneficiary if (1) the supplier has received an order for the item from a physician or certain non-physician practitioners, (2) there was a face-to-face encounter between the beneficiary and a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist within 6 months of the order, and (3) the physician documents the face-to-face encounter.

This provision permits physician assistants, nurse practitioners, or clinical nurse specialists to document that the Medicare beneficiary had a face-to-face encounter for purposes of coverage of item. This is effective on the date of enactment, and it permits the Secretary to implement the provision without formal notice and comment rulemaking (i.e., through program guidance or otherwise).

## **Sec. 505. Reducing Improper Medicare Payments**

This provision adds a new requirement under the agreements between the Secretary and Medicare Administrative Contractors (MACs) for the provision of ongoing outreach, education, training and technical assistance by MACs to Medicare providers of services and suppliers on improper payments. Each MAC must establish and regularly provide information that the Secretary determines appropriate for providers and suppliers in the region, including the following:

1. Quarterly lists of the most frequent and expensive payment errors, and instructions on how to correct or avoid those errors.
2. Notice of new topics for RAC audits, and instructions to avoid issues related to those audits.

MACs must prioritize their efforts to reduce improper payments for those items and services that have the highest rate of improper payment, that have the greatest aggregate amounts of improper payment, and that are due to clear misapplication or misinterpretation of policies or to common or inadvertent clerical/administrative error.

Of note is a requirement that RACs furnish (as frequently as quarterly) to each MAC complete lists of improper payments made to providers of services and suppliers in the MAC's region as well as additional information, such as providers and suppliers, and items and services, with the highest rates and greatest aggregate amounts of improper payments in the region.

MAC communications with providers and suppliers are subject to the strategy, requirements, and standards under existing law for communications with beneficiaries, providers of services, and suppliers, such as providing general written responses in a clear, concise, and accurate manner to inquiries, providing a toll-free number for inquiries, and maintaining a system to monitor which MAC employee provides the information and to monitor the accuracy, consistency, and timeliness of the information provided. Results are taken into account in evaluating performance of MACs.

Funding for these programs (as well as others described below) is derived by taking a portion (up to 15 percent) of the amounts otherwise retained by the Secretary under the RAC program, though there is a rule of construction reassuring RACs that the funding will not reduce amounts available for their payment. Additionally, funding may not be used for technology infrastructure, capital investments or information systems.

There is no effective date provision, so it is unclear whether the Secretary may renegotiate terms of existing contracts or whether the new requirements will apply to contracts entered into or renewed on or after the date of enactment.

### **Sec. 506. Improving Senior Medicare Patrol and Fraud Reporting Rewards**

The Secretary has 180 days to submit to Congress a plan to encourage individuals to report fraud and abuse in the Medicare program. The plan would include the following:

1. Revising the HIPAA section 203(b) incentive program.
2. Recommendations for enhancement of rewards.
3. Recommendations to extend the plan to the Medicaid program.
4. Recommendations to use the Senior Medicare Patrol program under section 411 of the Older Americans Act to encourage individuals to report fraud and abuse.

### **Sec. 507. Requiring Valid Prescriber National Provider Identifiers on Pharmacy Claims**

For plan years beginning after 2015, each claim for a Medicare covered part D drug (for an enrollee of a MA-PD plan under Part C, or of a prescription drug plan under Part D, of the Medicare program) must include a valid prescriber National Provider Identifier.

The Secretary, in consultation with stakeholders, must establish procedures for determining whether a prescriber National Provider Identifier on a claim for a covered part D drug is valid. Those procedures include informing an enrollee of the reason for the denial of a claim at the point of service when the claim for the covered part D drug is denied due to the lack of a valid prescriber National Provider Identifier.

The HHS OIG must submit a report to Congress on the effectiveness of the procedures by January 1, 2018.

### **Sec. 508. Option To Receive Medicare Summary Notice Electronically**

Beginning in 2016, a Medicare beneficiary may make an election to receive Medicare Explanation of Benefits (EOB) statements electronically rather than through the regular mail. The beneficiary may also revoke the election at least once; however, the Secretary may establish a limit on the number of elections the beneficiary may revoke.

Interestingly, the Secretary is not required to provide notice to beneficiaries of the electronic statement option before January 1, 2017. The notice must be done in a cost effective way, such as a notice included as part of the annual Medicare & You Handbook and through the Medicare toll-free number.

To the extent the Secretary determines it is appropriate, she must provide similar electronic receipt options to other statements and notices required under the Medicare program, and must provide those Medicare EOBs and other statutorily required statements and notices more frequently than is required under the statute.

### **Sec. 509. Renewal of MAC Contracts**

This provision doubles the length of a MAC contract from 5 to 10 years. This change applies to contracts in effect on or entered into after the date of enactment of the Act.

Current contracts include requirements to measure the performance of MACs (under requirements and standards developed by the Secretary in consultation with stakeholders) which are used to evaluate MAC performance under the contract. This provision requires the Secretary to make public the performance of MACs under these requirements and standards if it is possible to do so without “compromising the process for entering into and renewing” those contracts.

### **Sec. 510. Study on Pathway for Incentives to States for State Participation in Medicaid Data Match Program**

The Medicare Integrity Program includes a contract with eligible entities to ensure that the Medicare-Medicaid Data Match Program identifies vulnerabilities for payment anomalies and increases efficiency of both programs through cost-avoidance, savings, and recoupment of spending attributable to waste, fraud and abuse.

This provision requires the Secretary to study potential incentives for states to work with the Secretary, the Attorney General and the HHS OIG to coordinate activities to protect government spending under both programs. If the Secretary determines it appropriate, she may specify state incentives, including the waiver of provisions of title XI (General provisions, including waste, fraud and abuse, etc.) and title XIX (Medicaid program).

### **Sec. 511. Guidance on Application of Common Rule to Clinical Data Registries**

There are differences of opinion among stakeholders about whether the Common Rule (under subpart A of part 46 of title 45, CFR, protection of human subjects in research) applies to the collection of data (which includes identifiable patient information or protected health information under the HIPAA Privacy Rule) by clinical data registries or the individuals or entities submitting data to those registries. Some feel that the Common Rule should not apply to most clinical data registries because they do not receive federal funding or conduct federally-regulated research.

Within one year of the date of enactment, the Secretary must clarify (or modify) the application of the Common Rule to clinical data registries, including qualified clinical data registries used for purposes of the Medicare physician fee schedule.

### **Sec. 512. Eliminating Certain Civil Money Penalties; Gainsharing Study and Report**

Under section 1128A(b)(1) of the Social Security Act, a hospital is prohibited from making a payment, directly or indirectly, to induce a physician to reduce or limit services to Medicare or

Medicaid beneficiaries under the physician’s direct care. The statutory prohibition is broad, and there is no requirement that the prohibited payment be tied to a specific patient or to a reduction in care that is medically necessary. Gainsharing arrangements (arrangements that directly or indirectly provide physicians financial incentives to reduce or limit items or services to patients that are under the physicians’ clinical care) run afoul of the prohibition, and the OIG notes that “[a]bsent legislative relief, section 1128A(b)(1) of the Act prohibits any gainsharing arrangements that involve payments by or on behalf of a hospital to physicians with clinical care responsibilities, directly or indirectly, to induce a reduction or limitation of services to Medicare or Medicaid patients.” Subsection (a) would provide this legislative relief, effective (and applicable to payments made) on or after the date of enactment, by limiting the application of the beneficiary inducement CMP to reductions or limits in medically necessary care.

Within one year of the date of enactment, the Secretary and the HHS OIG must submit a report to Congress that includes options for amending the fraud and abuse laws under titles XI and XVIII (and related regulations) to permit Gainsharing arrangements. The report must consider the application of those options to ownership interests, compensation arrangements and other relationships as well as include recommendations for accountability, transparency, and quality. Congress is concerned about the potential for stinting on care, premature discharge of patients, and other reductions to medically necessary care. The report must also include a recommendation on whether any savings attributable to Gainsharing arrangements should accrue to the Medicare program.

### **Sec. 513. Modification of Medicare Home Health Surety Bond Condition of Participation Requirement**

Under current law, a home health agency must provide the Secretary with a surety bond that meets the following requirements:

1. It is effective for 4 years, or an additional period (of up to 4 years) in the case of a change in the ownership or control of the agency.
2. It must be in a form specified by the Secretary.
3. It must equal the lesser of \$50,000 or 10 percent of the aggregate amount of Medicare and Medicaid payments to the agency that Secretary determines is commensurate with the volume of the billing of the supplier.

This provision makes the following changes:

1. \$50,000 is the minimum amount of the surety bond.
2. The Secretary must still determine the amount of the surety bond and that amount must be commensurate with the volume of payments to the home health agency. However, any reference to Medicare and Medicaid payments in the revised language is omitted. Thus, one possible interpretation of this omission is that all payments from all payors should be taken into account.
3. There is no minimum period for the surety bond’s effectiveness stated in the statute.

The provision is effective on the date of the enactment of the Act.

## **Sec. 514. Oversight of Medicare Coverage of Manual Manipulation of the Spine To Correct Subluxation**

The Secretary must implement a medical review process for chiropractic services (consisting of manual manipulation of the spine to correct a subluxation) furnished to Medicare beneficiaries on or after January 1, 2017. The Secretary must focus first on those chiropractic services furnished by chiropractors with aberrant billing patterns or with a services denial percentage equal to or greater than the 85<sup>th</sup> percentile of denials (after factoring in results of appeals). Under the process, medical review consists of either prior authorization or pre- or post-payment review, and may be performed by any Medicare contractor the Secretary specifies (other than RACs).

*Prior authorization.* Under the medical review process, prior authorization is required for episodes of 12 or more services (as determined by diagnosis code or other indicator of the underlying cause). The Secretary must make a medical necessity determination before the service is furnished. A claim for the service may not be paid absent a determination that the service is medically necessary unless the Secretary fails to act on a prior authorization request in a timely manner (i.e., within 14 days of receipt of the requisite medical documentation). The requirement for prior authorization for a particular chiropractor may be tolled if he or she has a low denial rate during the period for which prior authorization is required; however CMS may at any time reinstate prior authorization based on higher rates of denials or aberrant billing patterns. Chiropractors may request prior authorization at any time before the twelfth service is furnished during an episode. The Secretary must, where practicable, provide for a single prior authorization for an episode, rather than on a service-by-service basis.

*Pre-payment or post-payment review.* Under the medical review process, pre- or post-payment review is used for services for which prior authorization is not required (i.e., for episodes consisting of fewer than 12 services). The protections of section 1879 of the Social Security Act apply to protect beneficiaries from financial liability for a claim that is denied under the pre- or post-payment review where the beneficiaries did not, or could not reasonably have been expected to, know that the services would not be covered.

Claims for services that have been affirmed under the medical review process may still be denied for other reasons established under the statute and regulations. The provision also states the following: “The Secretary may determine that medical review under this subsection does not apply in the case where potential fraud may be involved.”

The medical review process may be established through interim, final rulemaking, and the Secretary, in consultation with stakeholders, must by January 1, 2016, make education and training programs available to chiropractors on appropriate documentation to demonstrate medical necessity and reasonableness. Funding for these programs is made from a percentage retained by the Secretary from RAC recoveries (see section 505 above).

Within four years of enactment, GAO must submit to Congress a report on the effectiveness of the medical review process. The report will include aggregate data on the number of individuals, chiropractors and claims which could have been reviewed, as well as the number of claims actually reviewed and the outcomes of those reviews.

## **Sec. 515. National Expansion of Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport**

The Center for Medicare and Medicaid Innovation (CMMI) is testing a model for prior authorization for repetitive scheduled non-emergent ambulance transport in 3 states (New Jersey, Pennsylvania, and South Carolina). By January 1, 2016, the Secretary must expand that model to Delaware, D.C., Maryland, North Carolina, West Virginia and Virginia. A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished 3 or more times during a 10-day period, or at least once per week for at least 3 weeks (repetitive ambulance services are often needed by beneficiaries receiving dialysis or cancer treatment).

Beginning on January 1, 2017, the Secretary must expand the model nationwide if

- (1) the Secretary determines that expanding the model is expected to—
  - i. reduce Medicare spending without reducing the quality of care; or
  - ii. improve the quality of patient care without increasing Medicare spending;
- (2) the CMS Chief Actuary certifies that the expansion would reduce (or would not result in any increase in) net Medicare program spending; and
- (3) the Secretary determines that such expansion would not deny or limit the coverage or provision of Medicare benefits for beneficiaries.

Funding for the nationwide expansion is made from a percentage retained by the Secretary from RAC recoveries (see section 505 above). The provision includes a clarification that the CMMI is still required to terminate or modify a model being tested unless the model (i) improves the quality of care without increasing spending, (ii) reduces spending without reducing the quality of care; or (iii) improves the quality of care and reduces spending.

## **Sec. 516. Repealing Duplicative Medicare Secondary Payor Provision**

This provision would repeal what is described as a duplicative reporting requirement. Current law (under section 1862(b)(5)) requires the disclosure from the Internal Revenue Service to the Commissioner of Social Security and to CMS of certain taxpayer identity information for verification of the spouse of a Medicare beneficiary and of the employment status of a Medicare beneficiary. CMS forwards this information to MACs for purposes of the Medicare Secondary Payor (MSP) provisions. CMS also collects information from beneficiaries for MSP purposes before they become entitled under part A or enroll under part B.

This provision sunsets current law MSP information collection requirements with respect to information required to be provided on or after July 1, 2016. The provision also includes an effective date which indicates that the sunset applies to information required to be provided on or after January 1, 2016.

## **Sec. 517. Plan for Expanding Data in Annual CERT Report**

In less than 3 months' time (by June 30, 2015), the Secretary must submit to the congressional committees with jurisdiction over the Medicare program a plan to include data on certain physician services in the annual report on the Comprehensive Error Rate Testing program as well as by that date specific examples of those services.

The services at issue are those services, or groupings of services, which are paid under the Medicare physician fee schedule (MPFS) and that meet the following two requirements:

1. The MPFS amount for the service (or grouping) is greater than \$250.
2. The error rate for the service (or grouping) is greater than 20 percent.

The services at issue do not include medical visits.

### **Sec. 518. Removing Funds for Medicare Improvement Fund Added by Impact Act of 2014**

This provision depletes all funding (\$195,000,000) from the Medicare Improvement Fund.

### **Sec. 519. Rule of Construction**

This provision clarifies that CMS may use notice and comment rulemaking to carry out the provisions of this subtitle, including the amendments made to the Social Security Act.

### **Subtitle B – Other Provisions**

### **Sec. 521. Extension of Two-Midnight PAMA Rules on Certain Medical Review Activities**

Section 111 of the Protecting Access to Medicare Act of 2014 (PAMA) permitted the Secretary to continue medical review activities described in the notice entitled “Selecting Hospital Claims for Patient Status Reviews: Admissions On or After October 1, 2013” (the MAC probe and educate program) through the first 6 months of FY 2015. It also prohibited the Secretary from conducting patient status reviews on a post-payment basis through RACs for inpatient claims with dates of admission October 1, 2013 through March 31, 2015, unless there is evidence of systematic gaming, fraud, abuse, or delays in the provision of care by a provider.

This section amends both PAMA provisions to extend them another 6 months through the end of FY 2015. This section also adds a rule of construction that clarifies that these 6-month extensions do not limit the Secretary’s authority to carry out fraud and abuse activities under the Medicare Integrity Program (including through RACs) or otherwise.

### **Sec. 522. Requiring Bid Surety Bonds and State Licensure for Entities Submitting Bids under the Medicare DMEPOS Competitive Acquisition Program**

Section 1847 of the Social Security Act (DMEPOS competitive acquisition program provisions) does not currently include among the requirements for entities submitting bids that the entities obtain a bid surety bond (referred to as a “bid bond”) or that the entities meet applicable State licensure requirements (though the Secretary has authority to require State licensure).

Effective on the date of enactment, this provision requires bidding entities to meet applicable State licensure requirements (and clarifies that this requirement does not affect the Secretary’s prior authority to do so).

For rounds of competitive bidding beginning not earlier than January 1, 2017, and not later than January 1, 2019, in order to submit a bid for a competitive bidding area, a bidding entity must

obtain, by the bid deadline, a bid bond of between \$50,000 and \$100,000 for each competitive bidding area in which the entity submits a bid. The entity must prove to the Secretary that it obtained the requisite bond in a timely manner. Generally, bid bonds for a competitive bidding area will be returned to entities bidding for a product category in that area within 90 days of the public announcement of the contract suppliers. However, a bid bond will be forfeit (and the Secretary will collect on it) if a bidding entity rejects a contract offer from the Secretary for a product category and competitive bidding area where the entity's bid for that product category and area was equal to or less than the median composite bid rate for the product category and area. This may discourage a bidding entity from placing low bids and later rejecting the contract when the single payment amounts are lower than it wants.

GAO must evaluate the impact of the bid bond requirement on small suppliers seeking to participate in the DMEPOS competitive acquisition program. A report to Congress is required not later than 6 months after the first round of competitive bidding is conducted to which the bid bond requirement applies; the report must include recommendations for changes to ensure "robust participation by legitimate small suppliers" in the program.

### **Sec. 523. Payment for Global Surgical Packages**

In the CY 2015 MPFS final rule (CMS-1612-FC), the Secretary finalized a policy under which she would transition and revalue all 10- and 90- day global surgery services to 0-day global periods.

- The transition for 10-day global services would otherwise begin in CY 2017.
- The transition for 90-day global services would otherwise begin in CY 2018.

Section 523 prohibits the implementation of the transition to 0-day global periods under the CY 2015 MPFS final rule. However, the provision clarifies that the Secretary is nonetheless permitted to revalue misvalued codes for specific surgical services and to assign values to new or revised codes for surgical services. Nothing appears to preclude the Secretary from using 0-day global periods (on a code-by-code basis) when revaluing misvalued codes and when assigning values to new or revised codes for surgical services.

Beginning January 1, 2017, the Secretary may collect data from a representative sample of physicians to value surgical services, including information on the number and level of visits furnished during a global period as well as other the items and services furnished during the global period that are related to the surgery. The Secretary will specify the manner in which data will be reported which could be on claims at the end of the global period. \$2,000,000 is transferred from the Part B Trust Fund for FY 2015 (available until expended) for the data collection effort. The Secretary must reassess the value of the data collected every four years and may stop collecting data in this manner if sufficient information is available from other sources to accurately value global surgical services. The HHS OIG will audit a sample of the data collected to verify accuracy. Beginning in 2019, the Secretary must use the data collected to improve the accuracy of surgical services valuation.

To motivate physician participation, the Secretary may withhold 5 percent of payment amounts for surgical services under the MPFS until the physicians sampled report the requisite data.

## **Sec. 524. Extension of Secure Rural Schools and Community Self-Determination Act of 2000**

This section extends funding for FYs 2014 and 2015 for the Secure Rural Schools program under the Secure Rural Schools and Community Self-Determination Act of 2000. The provision also includes additional extensions for other programs under that Act. For more information on the programs, please see the following: <http://www.fs.usda.gov/pts/>.

## **Sec. 525. Exclusion from PAYGO Scorecards**

The budgetary effects of H.R. 2 are prohibited from being entered on any PAYGO scorecard maintained pursuant to section 4(d) of the Statutory Pay-As-You-Go Act of 2010 or section 201 of S. Con. Res. 21 (110<sup>th</sup> Congress). This provision is necessitated by the fact that the Congressional Budget Office (CBO) has estimated that the costs of the bill are not fully offset over 10 years. Under PAYGO, the Office of Management and Budget (OMB) must maintain both a five-year and a 10-year scorecard. One scorecard displays the costs or savings produced by legislation averaged over the first five years, and a second scorecard with the costs or savings averaged over the first 10 years. The costs or savings of every PAYGO bill enacted from February 12, 2010, onwards are recorded on the scorecards. At the end of each session of Congress, OMB adds all the (averaged) costs and savings for the fiscal year that has just started, to determine whether a sequestration is necessary.