Medicare SGR Repeal and Beneficiary Access Improvement Act of 2014

Section-by-Section

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Title I—Medicare Payment for Physicians' Services

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

This section repeals the SGR to provide long-term stability to the Medicare physician fee schedule. It provides stable updates for five years and ensures no changes are made to the current payment system for four years. In 2018, it establishes a streamlined and improved incentive payment program that will focus the fee-for-service system on providing value and quality. The incentive payment program, referred to as the Merit-Based Incentive Payment System (MIPS), consolidates the three existing incentive programs, continuing the focus on quality, resource use, and meaningful electronic health record (EHR) use with which professionals are familiar, but in a cohesive program that avoids redundancies. Further, this section provides financial incentive(s) for professionals to participate in tests of alternative payment models (APMs).

<u>Stabilizing Fee Updates</u>
The flawed SGR mechanism is permanently repealed, averting a 23.7 percent SGR-induced cut scheduled for April 1, 2014. Professionals will receive an annual update of 0.5 percent in each of 2014 through 2018. The rates in 2018 will be maintained through 2023, while providing professionals with the opportunity to receive additional payment adjustments through the MIPS. In 2024 and subsequent years, professionals participating in APMs that meet certain criteria would receive annual updates of one percent, while all other professionals would receive annual updates of 0.5 percent.

The Medicare Payment Advisory Commission (MedPAC) is required to submit reports to Congress in 2018 evaluating the impact that the 2014-2018 updates on beneficiary access and quality of care, with recommendations regarding further updates. MedPAC will also submit reports to Congress in 2017 and 2021 that assess the relationship between spending on services furnished by professionals under Medicare Part B and total expenditures under Medicare Parts A, B, and D. These reports recognize the critical role that professionals have in directing care and utilization by evaluating their impact on total program spending, including under the MIPS program.

<u>Consolidating Current Law Programs into a unified MIPS</u>
Payments to professionals will be adjusted based on performance in the unified MIPS starting in 2018. The MIPS streamlines and improves on the three distinct current law incentive programs:

- The Physician Quality Reporting System (PQRS) that incentivizes professionals to report on quality of care measures;
- The Value-Based Modifier (VBM) that adjusts payment based on quality and resource use in a budget-neutral manner; and

- Meaningful use of EHRs (EHR MU) that entails meeting certain requirements in the use of certified EHR systems.

Sunsetting Current Law Incentive Program Payment Implications

The payment implications associated with the current law incentive program penalties are sunset at the end of 2017, including the 2 percent penalty for failure to report PQRS quality measures and the 3 percent (increasing to 5 percent in 2019) penalty for failure to meet EHR MU requirements. The money from penalties that would have been assessed would now remain in the physician fee schedule, significantly increasing total payments compared to the current law baseline.

Professionals to Whom MIPS Applies

The MIPS will apply to: doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists beginning in 2018. Other professionals paid under the physician fee schedule may be included in the MIPS beginning in 2020, provided there are viable performance metrics available. Professionals who treat few Medicare patients, as well as professionals who receive a significant portion of their revenues from eligible APM(s) will be excluded from the MIPS.

MIPS Assessment Categories

The MIPS will assess the performance of eligible professionals in four categories: quality; resource use; EHR Meaningful Use; and clinical practice improvement activities.

1. Quality. Measures used for this performance category will be published annually in the final measures list developed under the methodology specified below. In addition to measures used in the existing quality performance programs (PQRS, VBM, EHR MU), the Secretary will solicit recommended measures and fund professional organizations and others to develop additional measures. Measures used by qualified clinical data registries may also be used to assess performance under this category.

2. Resource Use. The resource use category will include measures used in the existing VBM program. The methodology that CMS is currently developing to identify resources associated with specific care episodes would be enhanced through public input and an additional process that directly engages professionals. The additional process allows professionals to report their specific role in treating the beneficiary (e.g., primary care or specialist) and the type of treatment they deliver (e.g., chronic condition, acute episode). This additional process addresses concerns that algorithms and patient attribution formulas fail to accurately link the cost of services to a professional. Resource use measurement would also reflect additional research and recommendations on how to improve risk adjustment methodologies to ensure that professionals are not penalized for serving sicker or more costly patients.

3. Meaningful Use. Current EHR Meaningful Use requirements, demonstrated by use of a certified system, will continue to apply in order to receive credit in this category. To prevent duplicative reporting, professionals who report quality measures through certified

EHR systems for the MIPS quality category are deemed to meet the meaningful use clinical quality measure component.

4. Clinical Practice Improvement Activities. Professionals will be assessed on their effort to engage in clinical practice improvement activities. Incorporation of this new component gives credit to professionals working to improve their practices and facilitates future participation in APMs. The set of recognized activities will be established in collaboration with professionals. Activities must be applicable to all specialties and attainable for small practices and professionals in rural and underserved areas.

Annual List of Quality Measures Used in MIPS

Every year, the Secretary, through notice and comment rulemaking, will publish a list of quality measures to be used in the forthcoming MIPS performance period. Updates and modifications to the list of quality measures will also occur through this process. Eligible professionals will select which measures on the final list to report and be assessed on.

Eligible professional organizations and other relevant stakeholders will identify and submit quality measures to be considered for selection and submit updates to the measures already on the list. Measures may be submitted regardless of whether such measures were previously published in a proposed rule or endorsed by a consensus-based entity that holds a contract with the Centers for Medicare and Medicaid Services (CMS). Any measure selected for inclusion in such list that is not endorsed by a consensus-based entity must be evidence-based.

To the extent practicable, quality measures selected for inclusion on the final list will address five quality domains: clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. Before including a new measure in the final list, the Secretary will submit the measure for publication in an applicable specialty-appropriate peer-reviewed journal, including the method for developing and selecting the measure.

Qualified clinical data registry measures, many of which are maintained by physician specialty organizations, and existing quality measures will not be subject to these additional requirements and will be automatically included in the first program year's final list of quality measures. These measures will remain in the MIPS program unless they are removed under the rulemaking process.

Composite Performance Score

Professionals will receive a composite performance score of 0-100 based on their performance in each of the four performance categories listed above. Professionals will only be assessed on the categories, measures, and activities that apply to them. Scoring weights for performance categories, measures, and activities may be adjusted as necessary, to account for a professional's ability to successfully report on such category measure or activity and to ensure that individuals are measured on an equitable basis.

To incentivize improved performance, professionals will also receive credit for improvement from one year to the next in the determination of their quality and resource use performance

category score and may receive credit for improvement in clinical practice improvement activities.

MIPS Payment Adjustment

Each eligible professional's composite score will be compared to a performance threshold. The performance threshold will be the mean or median of the composite performance scores for all MIPS eligible professionals during a period prior to the performance period. Professionals will know what composite score they must achieve to obtain incentive payments and avoid penalties at the beginning of each performance period.

Payment adjustments will follow a linear distribution. Eligible professionals whose composite performance scores fall above the threshold will receive positive payment adjustments and eligible professionals whose composite performance scores fall below the threshold will receive negative payment adjustments.

- Negative adjustments – Negative payment adjustments will be capped at four percent in 2018, five percent in 2019, seven percent in 2020, and nine percent in 2021. Eligible professionals whose composite performance score falls between 0 and ¼ of the threshold will receive the maximum possible negative payment adjustment for the year. Professionals with composite performance scores closer to the threshold will receive proportionally smaller negative payment adjustments. These negative payment adjustments for eligible professionals whose composite performance scores fall below the threshold will fund positive payment adjustments to professionals with composite performance scores above the threshold.

- Zero adjustments – Eligible professionals whose composite performance score is at the threshold will not receive a MIPS payment adjustment.

- Positive adjustments – Eligible professionals whose composite performance scores are above the threshold will receive positive payment adjustments. Eligible professionals with higher performance scores will receive proportionally larger incentive payments up to a maximum of three times the annual cap for negative payment adjustments.

    - Additional Incentive Payment – An additional performance threshold for exceptional performance will be set at the 25th percentile of the range between the initial performance threshold and 100 (*e.g.*, if the performance threshold is a score of 60, the additional performance threshold would be a score of 70) or the 25th percentile of actual composite performance scores for MIPS eligible professionals with composite scores at or above the initial performance threshold (*i.e.*, 75 percent of professionals who receive a positive payment adjustment would receive an additional payment adjustment). Eligible professionals with composite scores above the additional performance threshold will receive an additional incentive payment. Aggregate additional incentive payments will be capped at $500 million per year for each of 2018 through 2023. Additional incentive payments will be allocated according to a linear distribution, with better performers receiving larger incentive payments. These payments will enable

some professionals to receive incentive payments even if all professionals score above the initial threshold.

A professional's payment adjustment in one year will have no impact on their payment adjustment in a future year.

The Government Accountability Office (GAO) is required to evaluate the MIPS and issue reports in 2018 and 2021, including an assessment of the professional types, practice sizes, practice geography, and patient mix that are receiving MIPS payment increases and decreases.

Expanded Participation Options and Tools to Enable Success

Professionals will have the flexibility to participate in MIPS in a way that best fits their practice environment. These options include: use of EHRs, use of qualified clinical data registries maintained by physician specialty organizations, and the option to be assessed as a group, as a "virtual" group, or with an affiliated hospital or facility.

Technical assistance will be available to help practices with 15 or fewer professionals improve MIPS performance or transition to APMs. Priority will be given to practices with low MIPS scores and those in rural and underserved areas. Funding will be $40 million annually from 2014 to 2018, with $10 million reserved for practices in areas designated as health professional shortage areas or medically underserved areas.

Professionals will receive confidential feedback on performance in the quality and resource use categories at least quarterly, likely through a web-based portal. Professionals may also receive confidential feedback on performance through qualified clinical data registries.

Encouraging Participation in APMs

Professionals who receive a significant share of their revenues through an APM(s) that involves the use of certified EHR technology, risk of financial losses, and a quality measurement component will receive a five percent bonus each year from 2018-2023. A patient-centered medical home APM will be exempted from the downside financial risk requirement if proven to reduce net spending in the Medicare population. Two options will be available for professionals to qualify for the bonus. The first option will be based on receiving a significant percent of Medicare revenue through an APM; the second option will be based on receiving a significant percent of APM revenue through a combination of Medicare and other payers. The second option makes it possible for professionals to qualify for the bonus even if Medicare APM options are limited in their area. If no Medicaid APM is available in a state, a professional's Medicaid revenue will not be counted against the proportion of revenue in an APM. In states where Medicaid APMs are available, Medicaid medical homes will also be exempted from downside financial risk if they are proven to work in the Medicaid population.

Professionals who meet these criteria will be excluded from the MIPS assessment.

The bonus payment for APM participation encourages professionals to consider participation in, and testing of, new APMs, recognizes that practice changes are needed to facilitate such participation, and promotes the alignment of incentives across payers.

To make the bonus opportunity available to the greatest number of professionals, the Secretary is specifically encouraged to test APMs relevant to specialty professionals, professionals in small practices, and those that align with private and state-based payer initiatives. Further, a Technical Advisory Committee (TAC) will be established to consider physician-focused APM proposals. CMS would be required to provide a detailed response to TAC-recommended APMs. The section also requires HHS to identify potential fraud vulnerabilities in APMs.

Sec. 102. Priorities and Funding for Quality Measure Development.

Measure Development Plan

Gaps in quality measurement programs will be addressed to ensure meaningful measures on which to assess professionals and funding will be provided for measure development priorities. The Secretary, with stakeholder input, is required to develop and publish a plan for the development of quality measures for use in the MIPS and in APMs, taking into account how measures from the private sector and integrated delivery systems could be utilized in the Medicare program. The plan, which must be finalized by May 1, 2015, will prioritize outcome measures, patient experience measures, care coordination measures, and measures of appropriate use of services, and consider gaps in quality measurement and applicability of measures across health care settings. The Secretary will contract with entities, which could include physician organizations, to develop priority measures and focus on measures that can be reported through an EHR.

Annual Report

By May 1, 2016, and annually thereafter, the Secretary is required to report on the progress made in developing quality measures. The report will include descriptions of the number of measures developed, including the name and type of each measure. The report will also include descriptions of the measures under development, an estimated timeline for completion of such measures, and a description of quality areas being considered for future measure development.

Funding

Funding will be $15 million annually in 2014 to 2018 for professional quality measure development. The funding will remain available through fiscal year 2021.

Sec. 103. Encouraging Care Management for Individuals with Chronic Care Needs.

At least one new payment code will be created to reimburse professionals managing care for individuals with chronic conditions. Payment for such services will be made to professionals practicing in a patient-centered medical home or comparable specialty practice certified by an organization(s) recognized by the Secretary. In order to prevent duplicative payments, only one professional or group practice will receive payment for these services provided to an individual during a specified period. Payment for these codes will be budget-neutral within the physician fee schedule. Finally, payments for chronic care management would not require that an annual wellness visit or an initial preventive physician examination be furnished as a condition of payment.

Sec. 104. Ensuring Accurate Valuation of Services Under the Physician Fee Schedule

Collection of Information to Assist in Accurate Valuation of Services

The Secretary is permitted to collect information from professionals and other providers and suppliers to assist in accurate valuation of service-level payments under the fee schedule. Such information may include: practice expense inputs, time involved in furnishing services, cost and charge data, and other elements the Secretary believes can be used to improve the valuation of services. The information may be collected via such mechanisms as surveys, practice logs, facility records, electronic health records, etc. The Secretary may only use this information in valuing services through notice and comment rulemaking. Starting in 2014, $2 million in annual funding is available to compensate professionals who submit the requested information.

Potentially Misvalued Codes

The list of criteria the Secretary can use to identify potentially misvalued services is expanded to include codes: that account for a majority of spending under the physician fee schedule; with substantial changes in procedure time; for which there may be a change in the site of service or a significant difference in payment between sites of service; services that may have greater efficiencies when performed together; or, with high practice expenses or high cost supplies.

The legislation sets an annual target for identifying misvalued services of 0.5 percent of the estimated amount of fee schedule expenditures in 2015, 2016, 2017, and 2018. If the target is met, that amount is redistributed in a budget-neutral manner within the physician fee schedule. If the target is not met, fee schedule payments for the year are reduced by the difference between the target and the amount of misvalued services identified in a given year. If the target is exceeded, the amount in excess of the target is credited toward the following year's target.

Beginning with the 2015 physician fee schedule, total downward relative value unit (RVU) adjustments for a service of 20 percent or more (as compared to the previous year) will be phased-in over a two-year period.

The Secretary is authorized to smooth differences in RVUs within a group of services, and GAO is required to study the AMA/Specialty Society Relative Value Scale Update Committee (RUC) processes for making recommendations on the valuation of physician services. The report is due no later than one year after enactment.

Adjustment to Medicare Payment Localities in California

Beginning January 1, 2017, fee schedule areas used for payment in California will transition from county-based localities, which have not been updated in 16 years, to Metropolitan Statistical Areas (MSAs), which are updated annually by the Office of Management and Budget (OMB) and used to organize and pay hospitals under the Medicare program. Payments for such areas shall transition over a six-year period. This modification would hold harmless professionals in certain transitional payment localities from negative payment adjustments.

Sec. 105. Promoting Evidence-Based Care

Selection of Appropriate Use Criteria

The Secretary is required to establish a program that promotes the use of appropriate use criteria (AUC) for advanced diagnostic imaging. In consultation with stakeholders, and no later than November 15, 2015, the Secretary will specify one or more AUC(s) from among those developed or endorsed by national professional medical specialty societies, taking into account whether such criteria have stakeholder consensus, are evidence-based, and are based on publicly available studies. The Secretary would not be permitted to develop or initiate the development of clinical practice guidelines or appropriate use criteria.

Selection of Qualified Clinical Decision Support (CDS) Mechanisms

In consultation with stakeholders, and no later than April 1, 2016, the Secretary will identify and publish a list of qualified CDS mechanisms, at least one of which must be free of charge, that could be used by ordering professionals to consult with applicable appropriate use criteria. Such mechanisms may be included in or independent from certified EHR technology and must: make available the applicable AUC(s) and supporting documentation; indicate the AUC(s) being used when more than one is available; determine the extent to which an imaging order follows the AUC(s); provide documentation to the ordering professional that such consultation occurred; be updated to reflect revisions to the AUC(s); and meet applicable privacy and security standards. The mechanism may be required to provide feedback to the ordering professional regarding that professional's aggregate adherence to applicable AUC(s).

Consultation with Qualified CDS Mechanisms

Beginning January 1, 2017, payment will only be made to the furnishing professional for an applicable advanced diagnostic imaging service if the claim for such service includes information: 1) showing that the ordering professional consulted with a qualified CDS mechanism; 2) as to whether the ordered service adheres to the applicable AUC(s); and 3) regarding the national provider identifier (NPI) of the ordering professional. The requirement to consult with AUC(s) does not apply to imaging services: ordered for an individual with an emergency medical condition as defined under EMTALA; paid under Part A; ordered by professionals for individuals attributed to a APM that meets certain criteria; or ordered by professionals who meet hardship criteria, such as lack of Internet access.

Prior Authorization

Beginning with 2017, and in consultation with stakeholders, the Secretary will identify ordering professionals with low adherence to applicable AUC(s) ("outliers") based on two years of data. Beginning January 1, 2020, outlier physicians shall be subject to prior authorization for applicable imaging services. Not more than five percent of ordering physicians can be subject to prior authorization. The legislation provides CMS with $5 million in each of 2019, 2020, and 2021 to carry out the prior authorization program.

GAO is required to provide a report to Congress no later than 18 months after enactment of this legislation regarding other Part B services for which the use of clinical decision support mechanism would be appropriate, such as radiation therapy and clinical diagnostic laboratory services.

Sec. 106. Empowering Beneficiary Choices through Access to Information on Physician Services

Not later than July 1, 2015, for physicians and July 1, 2016, for other professionals, in addition to the quality and resource use information that would be posted through the MIPS, the Secretary is required to publish utilization and payment data for professionals on the Physician Compare website. With emphasis on the services a professional most commonly furnishes, such information will include the number of services furnished and submitted charges and payments for such services and will be searchable by the eligible professional's name, provider type, specialty, location, and services furnished.

The website will indicate, where appropriate, that information may not be representative of the eligible professionals entire patient population, variety of services furnished, or the health conditions of the individuals treated. Professionals will to have an opportunity to review and correct this information prior to its posting on the website.

Sec. 107. Expanding Availability of Medicare Data

Qualified Entities

Consistent with relevant privacy and security laws, entities that currently receive Medicare data for public reporting purposes (qualified entities, "QEs") will be permitted to provide or sell non-public analyses and claims data to physicians, other professionals, providers, medical societies, and hospital associations to assist them in their quality improvement activities or in developing APMs. Any data or analyses must be de-identified, though the provider accessing the data or analysis can receive identifiable information on the services furnished to his or her patient. QEs will be permitted to provide or sell non-public analyses to health insurers (who provide claims data to the QE) and self-insured employers (only for purposes of providing health insurance to their employees or retirees). Providers identified in such analyses will have an opportunity to review and submit corrections before the QE provides or sells the analysis to other entities.

To ensure the privacy, security, and appropriate use of Medicare claims information, QEs must: have a data use agreement with providers and entities to which they provide data; and be subject to an assessment for breach of such agreement. Further, providers and entities receiving data and analyses are prohibited from re-disclosing them or using them for marketing.

QEs that provide or sell analyses or data shall provide an annual report to the Secretary that provides an accounting of: 1) the analyses provided or sold, including the number of analyses and purchasers, the amount of fees received, and the topics and purposes of the analyses; and 2) a list entities that were provided or sold data, the uses of that data, and the fees received by the QE for such data. The claims data available to QEs will also include Medicaid/CHIP data.

Qualified Clinical Data Registries

Consistent with relevant privacy and security laws, the Secretary is required to make data available, for a fee that covers the cost of preparing the data, to requesting qualified clinical data registries to support quality improvement and patient safety activities. Providers identified in public reports will have an opportunity to review and submit corrections.

Sec. 108. Reducing Administrative Burden and Other Provisions

Rule of Construction Regarding Standard of Care
Provides that the development, recognition, or implementation of any guideline or other standard under any Federal health care provision, including Medicare, cannot be construed to establish the standard of care or duty of care owed by a health care professional to a patient in any medical malpractice or medical product liability action or claim. This ensures that MIPS participation cannot be used in liability cases. This provision would not preempt any state or common law governing medical professional or medical product liability actions or claims.

Other Provisions

- Allows professionals who opt-out of Medicare to automatically renew at the end of each two-year cycle.
- Requires regular reporting of opt-out physician characteristics.
- Requires that Electronic Health Records (EHR) be interoperable by 2017 and prohibits providers from deliberately blocking information sharing with other EHR vendor products.
- Requires the Secretary to issue a report recommending how a permanent physician-hospital gainsharing program can best be established.
- Requires GAO to report on barriers to expanded use of telemedicine and remote patient monitoring.
- Requires the Secretary to publish information used to establish the multiple procedure payment reduction policy for imaging.

Title II—Extensions

Subtitle A.—Medicare Extensions

Sec. 201. Work Geographic Adjustment

Currently, the Medicare physician fee schedule is adjusted geographically for three factors—physician work, practice expense, and medical malpractice insurance—to reflect differences in the cost of resources needed to provide physician services. This is known as the Geographic Practice Cost Index (GPCI). A series of law set a temporary floor value of 1.00 on the physician work GPCI beginning January 2004 and continuing through March 31, 2014.

This section would permanently set the GPCI permanently set the GPCI floor at 1.0.

Sec. 202. Medicare Payment for Therapy Services

This section repeals the therapy cap. The $3,700 medical review threshold would be extended through the day before one year from the date of enactment, after which it would be repealed. Beginning 12 months after the date of enactment, a new medical review program for outpatient therapy services would be established. The Secretary will identify the services for medical review using appropriate factors. The Secretary will use prior authorization for the identified

outpatient therapy services furnished to a beneficiary above certain thresholds established by the Secretary.

The Secretary would end the application of prior authorization medical review if the provider has a low denial rate under prior authorization. The Secretary could subsequently reapply prior authorization medical review to the therapy provider if this were determined to be appropriate. The Secretary could use pre-payment review or post-payment review for services that are not subject to prior authorization medical review, including those services falling below the established thresholds.

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

To implement this subsection, the Secretary will provide for the transfer of $35,000,000 from the SMI Trust Fund to the CMS Program Management Account for each fiscal year, beginning with fiscal year 2014. These amounts will remain available until expended. Beginning with 2017 and then every two years, the Secretary will have to determine and publicly report the improper payment rate for outpatient therapy services for a 12-month period. If the improper payment rate is 50 percent or less of the Medicare FFS improper payment rate for the same period, the Secretary will have to reduce the amount of medical review conducted for a prospective year and return an appropriate portion of the funding provided for that year.

Sec. 203. Medicare Ambulance Services

This section extends all of the current temporary ambulance payments for an additional five years.

Additionally, the Secretary is required to develop a data collection system for ambulance providers and suppliers in consultation with stakeholders. The data collection system for ambulance services would include cost, revenue, utilization, and other information to evaluate appropriate payment rates, the utilization of capital equipment and ambulance capacity, and the different types of ambulance services furnished in different geographic regions. No later than July 1, 2015, the Secretary is required to specify the data collection methodology, the time period during which the data is required to be submitted, and to identify a sample of providers and suppliers required to submit such data. Beginning July 1, 2016, identified providers and suppliers who fail to submit such data would receive a five percent reduction in Medicare ambulance payments for a one-year prospective period specified by the Secretary.

The Secretary is permitted to revise the data collection system as appropriate, after consultation with providers and suppliers of ambulance services. Such consultation would include the use of requests for information and other appropriate mechanisms. For years after 2016, in order to continue to evaluate the appropriateness of payment rates, ambulance providers and suppliers are

required to submit such information no less than once every three years. If they do not, they will be subject to the five percent reduction in Medicare ambulance payments as described above.

Requirements under current law (44 *U.S.C.* §§ 3501-3521) regarding coordination of federal information, including the Paperwork Reduction Act, do not apply to the collection of this information. There is no administrative or judicial review of the data collection system or those identified as required to submit such information.

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

Sec. 204. Revision of the Medicare-Dependent Hospital (MDH) Program

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

This section makes the MDH program permanent.

Sec. 205. Revision of Medicare Inpatient Hospital Payment Adjustment for Low Volume Hospitals

Under the Medicare IPPS, certain low-volume hospitals receive a higher payment amount to account for their higher costs per discharge in 2012 and 2013. These hospitals must be located 15 miles or more from another comparable hospital. This adjustment expired on September 30, 2013.

This section makes the low-volume hospital payment policy permanent.

Sec. 206. Specialized Medicare Advantage Plans for Special Needs Individuals

This section permanently authorizes I-SNPs, re-authorizes D-SNPs through December 31, 2020, and re-authorizes C-SNPs through December 31, 2017. The Secretary must establish by, April 1, 2015, procedures that would unify the Medicare and Medicaid appeals procedures applicable to D-SNPs.

Beginning January 1, 2018, most D-SNPs will be required to integrate all Medicare and Medicaid benefits and meet the requirements for a FIDE-SNP, including, to the extent current state law under the state's Medicaid plan permitted capitated payments for long-term care services or behavioral health services. If the Secretary determines that D-SNPs failed to meet contract requirements for full integration of all Medicare and Medicaid benefits for 2018 or 2019, the Secretary is authorized to impose one of the following sanctions: 1) reduce MA

payments; 2) close enrollment to new plan enrollees; 3) apply MA sanctions, including civil money penalties and suspension; and 4) other reasonable actions as determined by the Secretary (except deeming that the plan no longer meets the definition of a D-SNP). Finally, in order to meet the definition of a D-SNP for 2020 and subsequent years, D-SNPs must fully integrate Medicare and Medicaid benefits and meet the current law definition of a FIDE-SNP.

This section also adds requirements to the C-SNP care management plans beginning with contracts effective January 1, 2016.

Beginning with contracts effective January 1, 2016, the Secretary is required to increase emphasis on SNPs' performance improvement or decline when determining a plan's annual star ratings.

Sec. 207. Reasonable Cost Reimbursement Contracts

Effective for plan year 2016, the Secretary may extend or renew cost contracts that had served an area where two or more local or regional MA plans with minimum enrollment had served in 2014, but would prohibit new enrollment into those cost contract plans for 2016.

Cost contract plans with restricted enrollment in 2016 will be able to apply to convert to a new Medicare Advantage plan starting in 2016, or have their contract terminated effective 2017.

The Secretary will be required to establish a process whereby the enrollees of the cost contract plans that convert to MA plans for 2017 will be automatically enrolled into the new MA plan.

Sec. 208. Quality Measure Endorsement and Selection

Generally, this section modifies the duties for the consensus-based entity, creates a new entity to carry out duties related to the selection of quality measures, and modifies the duties for the Secretary in a new section of the SSA. To carry out all these duties, this section provides funding of $7 million for FY2014 and $25 million for each of fiscal years 2015 through 2017. The changes are effective as of October 1, 2014, and will apply to contract periods that begin on or after October 1, 2014.

A new entity is created to carry out duties related to the selection of quality measures in order to allow more entities to bid for the contract and enhance the competitiveness of the process. The new entity must meet a number of requirements to qualify for becoming the measure selection entity. This section would transfer to the measure selection entity the following duties currently under the consensus-based entity: (1) priority setting, (2) the convening of multi-stakeholder groups, and (3) the transmission of multi-stakeholder input. This section would also create additional duties for the new measure selection entity. The entity would facilitate increased coordination and alignment between the public and private sectors with respect to quality and efficiency measures. The entity would have to conduct an ongoing analysis of gaps in endorsed quality and efficiency measures.

The consensus-based entity would be responsible for endorsing measures, obtaining feedback on the use of measures, and facilitating increased coordination and alignment between the public and private sector with respect to quality and efficiency measures.

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

Sec. 209. Permanent Extension of Funding Outreach and Assistance for Low-Income Programs

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

Subtitle B—Medicaid and Other Extensions

Sec. 211. Qualifying Individual Program

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

Sec. 212. Transitional Medical Assistance

Section 1925 TMA is extended through December 31, 2018. This section also permits states that: (1) take up the ACA Medicaid expansion and (2) take up a new continuous eligibility option to opt out of sections 1902(e) and 1925 TMA-related requirements.

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

Sec. 213. Express Lane Eligibility

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) created a state plan option for "Express Lane" eligibility whereby states are permitted to rely on

a finding from specified "Express Lane" agencies (*e.g.,* those that administer programs such as TANF and SNAP) for children's eligibility determinations and redeterminations. Authority for "Express Lane" eligibility determinations will sunset on September 30, 2014.

Under this section, the "Express Lane" eligibility determinations authority is extended until September 30, 2015.

Sec. 214. Pediatric Quality Measures

Funding is modified for adult quality measure development in SSA section 1139B to require the Secretary to spend at least $15 million of the $60 million appropriated on pediatric quality measure development under SSA section 1139A instead. This would provide the Secretary with the funding needed to continue the development of pediatric quality measures established under CHIPRA section 401(b) through September 30, 2015.

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

Sec. 215. Special Diabetes Programs

Funding is extended for both programs through FY2019. Specifically, $150 million is appropriated for each program annually.

Subtitle C—Human Services Extensions

Sec. 221. Abstinence Education Grants

Authorization and funding is extended for the SSA section 510 Abstinence Education program for five years, from FY2015 through FY2019, at $50 million for each year.

Sec. 222. Personal Responsibility Education Program

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

Sec. 223. Family-to-Family Heath Information Centers

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

Sec. 224. Health Workforce Demonstration Project for Low-Income Individuals

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

Title III—Medicare and Medicaid Program Integrity

Sec. 301. Reducing Improper Medicare Payments

This section would require the following three initiatives: an improper payment outreach and education program; enhanced RAC transparency, and a RAC demonstration project.

This section requires Medicare Administrative Contractors (MACs) to implement an improper payment outreach and education (OE) program to provide outreach, education, training, and technical assistance activities to providers and suppliers in their geographic service areas that focuses specifically on improper payments and Recovery Audit Contractor (RAC) audits.

To assist MACs in conducting the improper payment error reduction training program, the Secretary is required to supply MACs on a quarterly basis with a complete list of improper payments identified by RACs for the providers and suppliers in the MACs region. The quarterly list of improper payments identified by RACs that the Secretary would be required to supply would include the following information: 1) the providers and suppliers that have the highest improper payment rates; 2) the providers and suppliers that have the greatest improper payment amounts; 3) the items and services furnished in each MAC's geographic region that have the highest improper payment error rates; 4) the items and services in each MAC's geographic region that are responsible for the greatest improper payment amounts; and 5) other information the Secretary determines would be helpful to MACs in conducting the improper payment error reduction training program.

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

This section also adds information to the annual RAC report to Congress that is required under current law. Specifically, this section would require information on the results of appeals at each

appeal level for the following RAC review types: 1) automated, 2) complex, 3) medical necessity, 4) Part A, 5) Part B, and 6) durable medical equipment.

The section also requires the Secretary to conduct a three-year Medicare demonstration project to better target RAC audits.

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

Under the demonstration, the Secretary is required to adjust the number of records that could be requested from providers and suppliers by RACs. The Secretary is required to increase the maximum number of records that could be requested by RACs from providers and suppliers identified as having high error rates and decrease the maximum number of records that could be requested by RACs from providers and suppliers identified by composite scores as having low error rates.
The Secretary would have further authority under the demonstration to make additional adjustments to RAC requirements to offer incentives to reduce improper payment error rates for providers and suppliers assigned to either the low error rate group or the high error rate group. However, the Secretary would be prohibited from exempting any provider from being subject to RAC audits under the demonstration project.

Sec. 302. Authority for Medicaid Fraud Control Units to Investigate and Prosecute Complaints of Abuse and Neglect of Medicaid Patients in Home and Community-Based Settings

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

Sec. 303. Improved Use of Funds Received by the HHS Inspector General From Oversight and Investigative Activities

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

bill requires this funding to be designated for oversight and enforcement activities conducted by the HHS OIG.

Sec. 304. Preventing and Reducing Improper Medicare and Medicaid Expenditures

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

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

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

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

The HHS OIG is required to transmit to the Secretary the names and Social Security Numbers of individuals, the Secretary must disclose to the HHS OIG information on such individuals and their employers maintained in the NDNH. The HHS OIG may use this information to enforce mandatory and permissive exclusions under Title XI of the Social Security Act or evaluate the integrity of the Medicare program or a state health subsidy program.

The Secretary is required to establish a plan to encourage and facilitate the participation of states in the Medicare-Medicaid Data Match Program, or Medi-Medi Program. The Secretary is required to develop and implement a plan that allows state Medicaid programs access to relevant data on improper or fraudulent payments made under Medicare. This section makes technical changes to the Medi-Medi program to improve the participation of states.

Title IV—Other Provisions

Sec. 401. Commission on Improving Patient Directed Health Care

This section creates a Commission on Improving Patient Directed Health Care, which is a 15-member group charged with providing a forum for nationwide public debate in improving patient self-determination in health care decision-making; identifying strategies to ensure every American receives the health care they want; and providing recommendations to Congress. The Commission, which includes the Secretary and 14 GAO-appointed members selected to represent a diverse range of perspectives and experience, will conduct hearings across the country to allow Americans to provide input. The Commission will issue a Report to the American People on Patient Directed Health Care that, among other things, summarizes what the

Commission learned at its hearings and solicits comment from the public. Following close of the public comment period, the Commission will submit recommendations to the President and Congress. The Bill makes $3,000,000 available in each of fiscal years 2014 and 2015 for the Commission to conduct its work.

Sec. 402. Expansion of the Definition of Inpatient Hospital Services for Certain Cancer Hospitals

This section permits cancer hospitals that are located in the same building or on the same campus as another hospital as of the date of enactment to furnish routine services furnished after enactment under arrangement.

Sec. 403. Quality Measures for Certain Post-Acute Care Providers Relating to Notice and Transfer of Patient Health Information and Patient Care Preferences

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

Sec. 404. Criteria for Medically Necessary, Short Inpatient Hospital Stays

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

Sec. 405. Transparency of Reasons for Excluding Additional Procedures from the Medicare Ambulatory Surgical Center (ASC) Approved List

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

Medicare will not cover unlisted procedures associated with a specific anatomic location (for example, unlisted codes associated with eye procedures) in an ASC. CMS updates the lists of covered surgical procedures and ancillary services in ASCs as part of the ASC annual rulemaking process.

This section requires, for 2015 and beyond, the Secretary to describe the specific safety criteria for not finalizing procedures that were not proposed, but were requested to be included on the list of covered surgical procedures during the public comment period.

Sec. 406. Supervision in Critical Access Hospitals

This section allows for payment for general supervision of therapeutic hospital outpatient services at Critical Access Hospitals (CAHs).

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

Sec. 407. Requiring State Licensure of Bidding Entities Under the Competitive Acquisition Program for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

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

Sec. 408. Recognition of Attending Physician Assistants as Attending Physicians to Serve Hospice Patients

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

Sec. 409. Remote Patient Monitoring Pilot Projects

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

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

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

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

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

Sec. 410. Community-Based Institutional Special Needs Plan Demonstration Program

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

Sec. 411. Applying CMMI Waiver Authority to PACE in Order to Foster Innovations

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

Sec. 412. Improve and Modernize Medicaid Data Systems and Reporting

The Secretary is directed to implement a strategic plan to increase the usefulness of data about state Medicaid programs reported by states to CMS. The strategic plan will address redundancies and gaps in Medicaid data systems and reporting through improvements to, and modernization of, computer and data systems. Areas for improvement under the plan will include the following: (1) the reporting of encounter data by managed care plans; (2) the timeliness and quality of reported data, including enrollment data; (3) the consistency of data reported from multiple sources; and (4) information about state program policies. Within a year of enactment of the bill, the Secretary is required to submit a report to Congress on the status of implementation of the strategic plan.

Sec. 413. Fairness in Medicaid Supplemental Needs Trusts

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

This section will allow an individual with a disability, who otherwise qualifies for a section (d)(4)(A) trust, to create the trust independently.

Sec. 414. Helping Ensure Life and Limb-Saving Access to Podiatric Physicians

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

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

(1) Document that the individual has diabetes,

(2) Certify that the individual is under a comprehensive plan of care related to a diabetic condition, and

(3) Document agreement with the prescribing podiatrist or other qualified physician that the shoes are medically necessary.

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

(1) Examines the individual and determines the medical necessity for the individual to receive the therapeutic shoes,

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

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

Sec. 415. Demonstration Program to Improve Community Mental Health Services

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

To be eligible, states will be required to submit an application to the Secretary, conduct a financial assessment, comply with any other requirements as established by the Secretary, and certify that the behavioral health providers under the demonstration program meet certain specified criteria for certified clinics. States would also have to certify that providers of community mental health services meet new criteria and offer specific behavioral health services. Those services will then be reimbursed under Medicaid using a prospective payment system (PPS) based on the PPS for FQHCs under section 1902(bb) of the SSA. Those services will also be eligible for an enhanced federal match rate as defined under section 2105(b). In selecting states for the demonstration, considerations will be made for geographic diversity of participating states, including representation of certified clinics in rural and other underserved areas within those states. The Secretary will be able to waive the Medicaid statewideness requirement, which will permit states to offer different service packages in different areas.

The certified clinics will have to provide a number of services under the new criteria including: (1) crisis psychiatric services available on a 24-hour basis as well as psychiatric screenings; (2) evidence-based and integrated treatment for mental illness, substance abuse, and trauma; (3) peer support and counselor services for individuals and families; and (4) integrated preventive screenings for key health indicators.

The certified clinics would have to meet a number of additional requirements under the new criteria, including to (1) demonstrate the capacity to comply with behavioral health and related healthcare quality measures and (2) coordinate care across settings and providers including FQHCs, VA facilities, acute care hospitals, psychiatric hospitals, and other providers and social service organizations.

This section authorizes $27 million to be appropriated to carry out this section.

Sec. 416. Annual Medicaid DSH Report

Under this section, beginning January 1, 2015, the Secretary will annually submit a report to Congress on the Medicaid DSH payments for the purpose of providing Congress with information relevant to determining an appropriate level of overall funding for the payment

adjustments during and after 2014-2022, the period in which reductions to the DSH allotments are made.

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

Sec. 417. Implementation

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