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(Original Signature of Member)

113TH CONGRESS
2D SESSION

H. R. _____

To amend title XVIII of the Social Security Act to improve the integrity of the Medicare program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. BRADY of Texas (for himself and Mr. MCDERMOTT) introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XVIII of the Social Security Act to improve the integrity of the Medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Protecting the Integrity of Medicare Act of 2014''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Prohibition of inclusion of Social Security account numbers on Medicare cards.
Sec. 3. Preventing wrongful Medicare payments for items and services furnished to incarcerated individuals, individuals not lawfully present, and deceased individuals.
Sec. 4. Consideration of measures regarding Medicare beneficiary smart cards.
Sec. 5. Modifying medicare durable medical equipment face-to-face encounter documentation requirement.
Sec. 6. Reducing improper Medicare payments.
Sec. 7. Improving senior Medicare patrol and fraud reporting rewards.
Sec. 8. Requiring valid prescriber National Provider Identifiers on pharmacy claims.
Sec. 9. Option to receive Medicare Summary Notice electronically.
Sec. 10. Renewal of MAC contracts.
Sec. 11. Study on pathway for incentives to States for State participation in medicaid data match program.
Sec. 12. Programs to prevent prescription drug abuse under Medicare part D.
Sec. 13. Guidance on application of Common Rule to clinical data registries.
Sec. 14. Eliminating certain civil money penalties; gainsharing study and report.
Sec. 15. Modification of Medicare home health surety bond condition of participation requirement.
Sec. 16. Oversight of Medicare coverage of manual manipulation of the spine to correct subluxation.
Sec. 17. Limiting payment amount under Medicare program for vacuum erection systems.
Sec. 18. National expansion of prior authorization model for repetitive scheduled non-emergent ambulance transport.
Sec. 19. Repealing duplicative Medicare secondary payor provision.
Sec. 20. Plan for expanding data in annual CERT report.
Sec. 21. Rule of construction.

SEC. 2. PROHIBITION OF INCLUSION OF SOCIAL SECURITY ACCOUNT NUMBERS ON MEDICARE CARDS.

(a) IN GENERAL.—Section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)) is amended—

(1) by moving clause (x), as added by section 1414(a)(2) of the Patient Protection and Affordable Care Act, 6 ems to the left;

(2) by redesignating clause (x), as added by section 2(a)(1) of the Social Security Number Protection Act of 2010, and clause (xi) as clauses (xi) and (xii), respectively; and

(3) by adding at the end the following new clause:

''(xiii) The Secretary of Health and Human Services, in consultation with the Commissioner of Social Security, shall establish cost-effective procedures to ensure that a Social Security account number (or derivative thereof) is not displayed, coded, or embedded on the Medicare card issued to an individual who is entitled to benefits under part A of title XVIII or enrolled under part B of title XVIII and that any other identifier displayed on such card is not identifiable as a Social Security account number (or derivative thereof).''.

(b) IMPLEMENTATION.—In implementing clause (xiii) of section 205(c)(2)(C) of the Social Security Act (42 U.S.C. 405(c)(2)(C)), as added by subsection (a)(3), the Secretary of Health and Human Services shall do the following:

(1) IN GENERAL.—Establish a cost-effective process that involves the least amount of disruption to, as well as necessary assistance for, Medicare beneficiaries and health care providers, such as a process that provides such beneficiaries with access to assistance through a toll-free telephone number and provides outreach to providers.

(2) CONSIDERATION OF MEDICARE BENEFICIARY IDENTIFIED.—Consider implementing a process, similar to the process involving Railroad Retirement Board beneficiaries, under which a Medicare beneficiary identifier which is not a Social Security account number (or derivative thereof) is used external to the Department of Health and Human Services and is convertible over to a Social Security account number (or derivative thereof) for use internal to such Department and the Social Security Administration.

(c) FUNDING FOR IMPLEMENTATION.—For purposes of implementing the provisions of and the amendments made by this section, the Secretary of Health and Human Services shall provide for the following transfers from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportions as the Secretary determines appropriate:

(1) To the Centers for Medicare & Medicaid Program Management Account, transfers of the following amounts:

(A) For fiscal year 2015, $65,000,000, to be made available through fiscal year 2018.

(B) For each of fiscal years 2016 and 2017, $53,000,000, to be made available through fiscal year 2018.

(C) For fiscal year 2018, $48,000,000, to be made available until expended.

(2) To the Social Security Administration Limitation on Administration Account, transfers of the following amounts:

(A) For fiscal year 2015, $27,000,000, to be made available through fiscal year 2018.

(B) For each of fiscal years 2016 and 2017, $22,000,000, to be made available through fiscal year 2018.

(C) For fiscal year 2018, $27,000,000, to be made available until expended.

(3) To the Railroad Retirement Board Limitation on Administration Account, the following amount:

(A) For fiscal year 2015, $3,000,000, to be made available until expended.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Clause (xiii) of section 205(c)(2)(C) of the Social Security Act (42 U.S.C.

405(c)(2)(C)), as added by subsection (a)(3), shall apply with respect to Medicare cards issued on and after an effective date specified by the Secretary of Health and Human Services, but in no case shall such effective date be later than the date that is four years after the date of the enactment of this Act.

(2) REISSUANCE.—The Secretary shall provide for the reissuance of Medicare cards that comply with the requirements of such clause not later than four years after the effective date specified by the Secretary under paragraph (1).

SEC. 3. PREVENTING WRONGFUL MEDICARE PAYMENTS FOR ITEMS AND SERVICES FURNISHED TO INCARCERATED INDIVIDUALS, INDIVIDUALS NOT LAWFULLY PRESENT, AND DECEASED INDIVIDUALS.

(a) REQUIREMENT FOR THE SECRETARY TO ESTABLISH POLICIES AND CLAIMS EDITS RELATING TO INCARCERATED INDIVIDUALS, INDIVIDUALS NOT LAWFULLY PRESENT, AND DECEASED INDIVIDUALS.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

''(f) REQUIREMENT FOR THE SECRETARY TO ESTABLISH POLICIES AND CLAIMS EDITS RELATING TO INCARCERATED INDIVIDUALS, INDIVIDUALS NOT LAWFULLY

PRESENT, AND DECEASED INDIVIDUALS.—The Secretary shall establish and maintain procedures, including procedures for using claims processing edits, updating eligibility information to improve provider accessibility, and conducting recoupment activities such as through recovery audit contractors, in order to ensure that payment is not made under this title for items and services furnished to an individual who is one of the following:

''(1) An individual who is incarcerated.

''(2) An individual who is not lawfully present in the United States and who is not eligible for coverage under this title.

''(3) A deceased individual.''.

(b) REPORT.—Not later than 18 months after the date of the enactment of this section, and periodically thereafter as determined necessary by the Office of Inspector General of the Department of Health and Human Services, such Office shall submit to Congress a report on the activities described in subsection (f) of section 1874 of the Social Security Act (42 U.S.C. 1395kk), as added by subparagraph (a), that have been conducted since such date of enactment.

SEC. 4. CONSIDERATION OF MEASURES REGARDING MEDICARE BENEFICIARY SMART CARDS.

To the extent the Secretary of Health and Human Services determines that it is cost effective and technologically viable to use electronic Medicare beneficiary and provider cards (such as cards that use smart card technology, including an embedded and secure integrated circuit chip), as presented in the Government Accountability Office report required by the conference report accompanying the Consolidated Appropriations Act, 2014 (Public Law 113–76), the Secretary shall consider such measures as determined appropriate by the Secretary to implement such use of such cards for beneficiary and provider use under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). In the case that the Secretary considers measures under the preceding sentence, the Secretary shall submit to the Committees on Ways and Means and on Energy and Commerce of the House of Representatives, and to the Committee on Finance of the Senate, a report outlining the considerations undertaken by the Secretary under such sentence.

SEC. 5. MODIFYING MEDICARE DURABLE MEDICAL EQUIPMENT FACE-TO-FACE ENCOUNTER DOCUMENTATION REQUIREMENT.

(a) IN GENERAL.—Section 1834(a)(11)(B)(ii) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)(ii)) is amended—

(1) by striking ''the physician documenting that''; and

(2) by striking ''has had a face-to-face encounter'' and inserting ''documenting such physician, physician assistant, practitioner, or specialist has had a face-to-face encounter''.

(b) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by subsection (a) by program instruction or otherwise.

SEC. 6. REDUCING IMPROPER MEDICARE PAYMENTS.

(a) MEDICARE ADMINISTRATIVE CONTRACTOR IMPROPER PAYMENT OUTREACH AND EDUCATION PROGRAM.—

(1) IN GENERAL.—Section 1874A of the Social Security Act (42 U.S.C. 1395kk–1) is amended—

(A) in subsection (a)(4)—

(i) by redesignating subparagraph (G) as subparagraph (H); and

(ii) by inserting after subparagraph (F) the following new subparagraph:

''(G) IMPROPER PAYMENT OUTREACH AND EDUCATION PROGRAM.—Having in place an improper payment outreach and education program described in subsection (h).''; and

(B) by adding at the end the following new subsection:

''(h) IMPROPER PAYMENT OUTREACH AND EDUCATION PROGRAM.—

''(1) IN GENERAL.—In order to reduce improper payments under this title, each medicare administrative contractor shall establish and have in place an improper payment outreach and education program under which the contractor, through outreach, education, training, and technical assistance or other activities, shall provide providers of services and suppliers located in the region covered by the contract under this section with the information described in paragraph (2). The activities described in the preceding sentence shall be conducted on a regular basis.

''(2) INFORMATION TO BE PROVIDED THROUGH ACTIVITIES.—The information to be provided under such payment outreach and education program shall

include information the Secretary determines to be appropriate which may include the following information:

''(A) A list of the providers' or suppliers' most frequent and expensive payment errors over the last quarter.

''(B) Specific instructions regarding how to correct or avoid such errors in the future.

''(C) A notice of new topics that have been approved by the Secretary for audits conducted by recovery audit contractors under section 1893(h).

''(D) Specific instructions to prevent future issues related to such new audits.

''(E) Other information determined appropriate by the Secretary.

''(3) PRIORITY.—A medicare administrative contractor shall give priority to activities under such program that will reduce improper payments that are one or more of the following:

''(A) Are for items and services that have the highest rate of improper payment.

''(B) Are for items and service that have the greatest total dollar amount of improper payments.

''(C) Are due to clear misapplication or misinterpretation of Medicare policies.

''(D) Are clearly due to common and inadvertent clerical or administrative errors.

''(E) Are due to other types of errors that the Secretary determines could be prevented through activities under the program.

''(4) INFORMATION ON IMPROPER PAYMENTS FROM RECOVERY AUDIT CONTRACTORS.—

''(A) IN GENERAL.—In order to assist medicare administrative contractors in carrying out improper payment outreach and education programs, the Secretary shall provide each contractor with a complete list of the types of improper payments identified by recovery audit contractors under section 1893(h) with respect to providers of services and suppliers located in the region covered by the contract under this section. Such information shall be provided on a time frame the Secretary determines appropriate which may be on a quarterly basis.

''(B) INFORMATION.—The information described in subparagraph (A) shall include information such as the following:

''(i) Providers of services and suppliers that have the highest rate of improper payments.

''(ii) Providers of services and suppliers that have the greatest total dollar amounts of improper payments.

''(iii) Items and services furnished in the region that have the highest rates of improper payments.

''(iv) Items and services furnished in the region that are responsible for the greatest total dollar amount of improper payments.

''(v) Other information the Secretary determines would assist the contractor in carrying out the program.

''(5) COMMUNICATIONS.—Communications with providers of services and suppliers under an improper payment outreach and education program are subject to the standards and requirements of subsection (g).''.

(b) USE OF CERTAIN FUNDS RECOVERED BY RACS.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (2), by inserting ''or section 1874(h)(6)'' after ''paragraph (1)(C)''; and

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

''(10) USE OF CERTAIN RECOVERED FUNDS.—

''(A) IN GENERAL.—After application of paragraph (1)(C), the Secretary shall retain a portion of the amounts recovered by recovery audit contractors for each year under this section which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of, subject to subparagraph (B), carrying out sections 1833(z), 1834(l)(16), and 1874A(a)(4)(G), carrying out section 16(b) of the Protecting the Integrity of Medicare Act of 2014, and implementing strategies (such as claims processing edits) to help reduce the error rate of payments under this title. The amounts retained under the preceding sentence shall not exceed an amount equal to 15 percent of the amounts recovered under this subsection, and shall remain available until expended.

''(B) LIMITATION.—Except for uses that support claims processing (including edits) or

system functionality for detecting fraud, amounts retained under subparagraph (A) may not be used for technological-related infrastructure, capital investments, or information systems.

''(C) NO REDUCTION IN PAYMENTS TO RECOVERY AUDIT CONTRACTORS.—Nothing in subparagraph (A) shall reduce amounts available for payments to recovery audit contractors under this subsection.''.

SEC. 7. IMPROVING SENIOR MEDICARE PATROL AND FRAUD REPORTING REWARDS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan to revise the incentive program under section 203(b) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1395b-5(b)) to encourage greater participation by individuals to report fraud and abuse in the Medicare program. Such plan shall include recommendations for—

(1) ways to enhance rewards for individuals reporting under the incentive program, including rewards based on information that leads to an administrative action; and

(2) extending the incentive program to the Medicaid program.

(b) PUBLIC AWARENESS AND EDUCATION CAMPAIGN.—The plan developed under subsection (a) shall also include recommendations for the use of the Senior Medicare Patrols authorized under section 411 of the Older Americans Act of 1965 (42 U.S.C. 3032) to conduct a public awareness and education campaign to encourage participation in the revised incentive program under subsection (a).

(c) SUBMISSION OF PLAN.—Not later than 180 days after the date of enactment of this Act, the Secretary shall submit to Congress the plan developed under subsection (a).

SEC. 8. REQUIRING VALID PRESCRIBER NATIONAL PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.

Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

''(4) REQUIRING VALID PRESCRIBER NATIONAL PROVIDER IDENTIFIERS ON PHARMACY CLAIMS.—

''(A) IN GENERAL.—For plan year 2016 and subsequent plan years, the Secretary shall require a claim for a covered part D drug for a part D eligible individual enrolled in a pre-

scription drug plan under this part or an MA-PD plan under part C to include a prescriber National Provider Identifier that is determined to be valid under the procedures established under subparagraph (B)(i).

''(B) PROCEDURES.—

''(i) VALIDITY OF PRESCRIBER NATIONAL PROVIDER IDENTIFIERS.—The Secretary, in consultation with appropriate stakeholders, shall establish procedures for determining the validity of prescriber National Provider Identifiers under subparagraph (A).

''(ii) INFORMING BENEFICIARIES OF REASON FOR DENIAL.—The Secretary shall establish procedures to ensure that, in the case that a claim for a covered part D drug of an individual described in subparagaph (A) is denied because the claim does not meet the requirements of this paragraph, the individual is properly informed at the point of service of the reason for the denial.

''(C) REPORT.—Not later than January 1, 2018, the Inspector General of the Department

of Health and Human Services shall submit to Congress a report on the effectiveness of the procedures established under subparagraph (B)(i).''.

SEC. 9. OPTION TO RECEIVE MEDICARE SUMMARY NOTICE ELECTRONICALLY.

(a) IN GENERAL.—Section 1806 of the Social Security Act (42 U.S.C. 1395b–7) is amended by adding at the end the following new subsection:

''(c) FORMAT OF STATEMENTS FROM SECRETARY.—

''(1) ELECTRONIC OPTION BEGINNING IN 2016.—Subject to paragraph (2), for statements described in subsection (a) that are furnished for a period in 2016 or a subsequent year, in the case that an individual described in subsection (a) elects, in accordance with such form, manner, and time specified by the Secretary, to receive such statement in an electronic format, such statement shall be furnished to such individual for each period subsequent to such election in such a format and shall not be mailed to the individual.

''(2) LIMITATION ON REVOCATION OPTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary may determine a maximum number of elections described in para-

graph (1) by an individual that may be revoked by the individual.

"(B) MINIMUM OF ONE REVOCATION OPTION.—In no case may the Secretary determine a maximum number under subparagraph (A) that is less than one.

"(3) NOTIFICATION.—The Secretary shall ensure that, in the most cost effective manner and beginning January 1, 2017, a clear notification of the option to elect to receive statements described in subsection (a) in an electronic format is made available, such as through the notices distributed under section 1804, to individuals described in subsection (a).".

(b) ENCOURAGED EXPANSION OF ELECTRONIC STATEMENTS.—To the extent to which the Secretary of Health and Human Services determines appropriate, the Secretary shall—

(1) apply an option similar to the option described in subsection (c)(1) of section 1806 of the Social Security Act (42 U.S.C. 1395b–7) (relating to the provision of the Medicare Summary Notice in an electronic format), as added by subsection (a), to other statements and notifications under title XVIII of such Act (42 U.S.C. 1395 et seq.); and

(2) provide such Medicare Summary Notice and any such other statements and notifications on a more frequent basis than is otherwise required under such title.

SEC. 10. RENEWAL OF MAC CONTRACTS.

(a) IN GENERAL.—Section 1874A(b)(1)(B) of the Social Security Act (42 U.S.C. 1395kk–1(b)(1)(B)) is amended by striking ''5 years'' and inserting ''10 years''.

(b) APPLICATION.—The amendments made by subsection (a) shall apply to contracts entered into on or after, and to contracts in effect as of, the date of the enactment of this Act.

(c) CONTRACTOR PERFORMANCE TRANSPARENCY.—Section 1874A(b)(3)(A) of the Social Security Act (42 U.S.C. 1395kk–1(b)(3)(A)) is amended by adding at the end the following new clause:

''(iv) CONTRACTOR PERFORMANCE TRANSPARENCY.—To the extent possible without compromising the process for entering into and renewing contracts with medicare administrative contractors under this section, the Secretary shall make available to the public the performance of each medicare administrative contractor

with respect to such performance requirements and measurement standards.''.

SEC. 11. STUDY ON PATHWAY FOR INCENTIVES TO STATES FOR STATE PARTICIPATION IN MEDICAID DATA MATCH PROGRAM.

Section 1893(g) of the Social Security Act (42 U.S.C. 1395ddd(g)) is amended by adding at the end the following new paragraph:

''(3) INCENTIVES FOR STATES.—The Secretary shall study and, as appropriate, may specify incentives for States to work with the Secretary for the purposes described in paragraph (1)(A)(ii). The application of the previous sentence may include use of the waiver authority described in paragraph (2).''.

SEC. 12. PROGRAMS TO PREVENT PRESCRIPTION DRUG ABUSE UNDER MEDICARE PART D.

(a) DRUG MANAGEMENT PROGRAM FOR AT-RISK BENEFICIARIES.—

(1) IN GENERAL.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–10(c)), as amended by section 8, is further amended by adding at the end the following:

''(5) DRUG MANAGEMENT PROGRAM FOR AT-RISK BENEFICIARIES.—

''(A) AUTHORITY TO ESTABLISH.—A PDP sponsor may establish a drug management program for at-risk beneficiaries under which, subject to subparagraph (B), the PDP sponsor may, in the case of an at-risk beneficiary for prescription drug abuse who is an enrollee in a prescription drug plan of such PDP sponsor, limit such beneficiary's access to coverage for frequently abused drugs under such plan to frequently abused drugs that are prescribed for such beneficiary by a prescriber selected under subparagraph (D), and dispensed for such beneficiary by a pharmacy selected under such subparagraph.

''(B) REQUIREMENT FOR NOTICES.—

''(i) IN GENERAL.—A PDP sponsor may not limit the access of an at-risk beneficiary for prescription drug abuse to coverage for frequently abused drugs under a prescription drug plan until such sponsor—

''(I) provides to the beneficiary an initial notice described in clause (ii) and a second notice described in clause (iii); and

''(II) verifies with the providers of the beneficiary that the beneficiary is an at-risk beneficiary for prescription drug abuse.

''(ii) INITIAL NOTICE.—An initial notice described in this clause is a notice that provides to the beneficiary—

''(I) notice that the PDP sponsor has identified the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse;

''(II) information describing all State and Federal public health resources that are designed to address prescription drug abuse to which the beneficiary has access, including mental health services and other counseling services;

''(III) notice of, and information about, the right of the beneficiary to appeal such identification under subsection (h) and the option of an automatic escalation to external review;

''(IV) a request for the beneficiary to submit to the PDP sponsor

preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor to select under subparagraph (D) in the case that the beneficiary is identified as an at-risk beneficiary for prescription drug abuse as described in clause (iii)(I);

''(V) an explanation of the meaning and consequences of the identification of the beneficiary as potentially being an at-risk beneficiary for prescription drug abuse, including an explanation of the drug management program established by the PDP sponsor pursuant to subparagraph (A);

''(VI) clear instructions that explain how the beneficiary can contact the PDP sponsor in order to submit to the PDP sponsor the preferences described in subclause (IV) and any other communications relating to the drug management program for at-risk beneficiaries established by the PDP sponsor; and

''(VII) contact information for other organizations that can provide the beneficiary with assistance regarding such drug management program (similar to the information provided by the Secretary in other standardized notices provided to part D eligible individuals enrolled in prescription drug plans under this part).

''(iii) SECOND NOTICE.—A second notice described in this clause is a notice that provides to the beneficiary notice—

''(I) that the PDP sponsor has identified the beneficiary as an at-risk beneficiary for prescription drug abuse;

''(II) that such beneficiary is subject to the requirements of the drug management program for at-risk beneficiaries established by such PDP sponsor for such plan;

''(III) of the prescriber and pharmacy selected for such individual under subparagraph (D);

''(IV) of, and information about, the beneficiary's right to appeal such identification under subsection (h) and the option of an automatic escalation to external review;

''(V) that the beneficiary can, in the case that the beneficiary has not previously submitted to the PDP sponsor preferences for which prescribers and pharmacies the beneficiary would prefer the PDP sponsor select under subparagraph (D), submit such preferences to the PDP sponsor; and

''(VI) that includes clear instructions that explain how the beneficiary can contact the PDP sponsor.

''(iv) TIMING OF NOTICES.—

''(I) IN GENERAL.—Subject to subclause (II), a second notice described in clause (iii) shall be provided to the beneficiary on a date that is not less than 60 days after an initial notice described in clause (ii) is provided to the beneficiary.

''(II) EXCEPTION.—In the case that the PDP sponsor, in conjunction with the Secretary, determines that concerns identified through rule-making by the Secretary regarding the health or safety of the beneficiary or regarding significant drug diversion activities require the PDP sponsor to provide a second notice described in clause (iii) to the beneficiary on a date that is earlier than the date described in subclause (II), the PDP sponsor may provide such second notice on such earlier date.

''(C) AT-RISK BENEFICIARY FOR PRESCRIPTION DRUG ABUSE.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'at-risk beneficiary for prescription drug abuse' means a part D eligible individual who is not an exempted individual described in clause (ii) and—

''(I) who is identified through the use of guidelines developed by the Secretary in consultation with PDP

sponsors and other stakeholders described in section 12(f)(2)(A) of the Protecting the Integrity of Medicare Act of 2014; or

''(II) with respect to whom the PDP sponsor of a prescription drug plan, upon enrolling such individual in such plan, received notice from the Secretary that such individual was identified under this paragraph to be an at-risk beneficiary for prescription drug abuse under the prescription drug plan in which such individual was most recently previously enrolled and such identification has not been terminated under subparagraph (F).

''(ii) EXEMPTED INDIVIDUAL DESCRIBED.—An exempted individual described in this clause is an individual who—

''(I) receives hospice care under this title; or

''(II) the Secretary elects to treat as an exempted individual for purposes of clause (i).

''(D) SELECTION OF PRESCRIBERS.—

''(i) IN GENERAL.—With respect to each at-risk beneficiary for prescription drug abuse enrolled in a prescription drug plan offered by such sponsor, a PDP sponsor shall, based on the preferences submitted to the PDP sponsor by the beneficiary pursuant to clauses (ii)(IV) and (iii)(V) of subparagraph (B), select—

''(I) one or more individuals who are authorized to prescribe frequently abused drugs (referred to in this paragraph as 'prescribers') who may write prescriptions for such drugs for such beneficiary; and

''(II) one or more pharmacies that may dispense such drugs to such beneficiary.

''(ii) REASONABLE ACCESS.—In making the selection under this subparagraph, a PDP sponsor shall ensure that the beneficiary continues to have reasonable access to drugs described in subparagraph (G), taking into account geographic location,

beneficiary preference, affordability, and reasonable travel time.

"(iii) BENEFICIARY PREFERENCES.—

"(I) IN GENERAL.—If an at-risk beneficiary for prescription drug abuse submits preferences for which in-network prescribers and pharmacies the beneficiary would prefer the PDP sponsor select in response to a notice under subparagraph (B), the PDP sponsor shall—

"(aa) review such preferences;

"(bb) select or change the selection of a prescriber or pharmacy for the beneficiary based on such preferences; and

"(cc) inform the beneficiary of such selection or change of selection.

"(II) EXCEPTION.—In the case that the PDP sponsor determines that a change to the selection of a prescriber or pharmacy under item (bb) by the PDP sponsor is contributing or

would contribute to prescription drug abuse or drug diversion by the beneficiary, the PDP sponsor may change the selection of a prescriber or pharmacy for the beneficiary without regard to the preferences of the beneficiary described in subclause (I).

''(iv) CONFIRMATION.—Before selecting a prescriber or pharmacy under this subparagraph, a PDP sponsor must request and receive confirmation from the prescriber or pharmacy acknowledging and accepting that the beneficiary involved is in the drug management program for at-risk beneficiaries.

''(E) TERMINATIONS AND APPEALS.—The identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph, a coverage determination made under a drug management program for at-risk beneficiaries, and the selection of a prescriber or pharmacy under subparagraph (D) with respect to such individual shall be subject to reconsideration and appeal under subsection (h) and the option of an automatic escalation to ex-

ternal review to the extent provided by the Secretary.

''(F) TERMINATION OF IDENTIFICATION.—

''(i) IN GENERAL.—The Secretary shall develop standards for the termination of identification of an individual as an at-risk beneficiary for prescription drug abuse under this paragraph. Under such standards such identification shall terminate as of the earlier of—

''(I) the date the individual demonstrates that the individual is no longer likely, in the absence of the restrictions under this paragraph, to be an at-risk beneficiary for prescription drug abuse described in subparagraph (C)(i); or

''(II) the end of such maximum period of identification as the Secretary may specify.

''(ii) RULE OF CONSTRUCTION.—Nothing in clause (i) shall be construed as preventing a plan from identifying an individual as an at-risk beneficiary for prescription drug abuse under subparagraph

(C)(i) after such termination on the basis of additional information on drug use occurring after the date of notice of such termination.

''(G) FREQUENTLY ABUSED DRUG.—For purposes of this subsection, the term 'frequently abused drug' means a drug that is determined by the Secretary to be frequently abused or diverted and that is—

''(i) a Controlled Drug Substance in Schedule CII-CIV;

''(ii) within the same class or category of drugs as a Controlled Drug Substance in Schedule CII-CIV; or

''(iii) within another class or category of drugs that the Secretary determines, in consultation with the Inspector General of the Department of Health and Human Services, is at high risk for diversion or abuse.

''(H) DATA DISCLOSURE.—In the case of an at-risk beneficiary for prescription drug abuse whose access to coverage for frequently abused drugs under a prescription drug plan has been limited by a PDP sponsor under this

paragraph, such PDP sponsor shall disclose data, including any necessary individually identifiable health information, in a form and manner specified by the Secretary, about the decision to impose such limitations and the limitations imposed by the sponsor under this part.

''(I) EDUCATION.—The Secretary shall provide education to enrollees in prescription drug plans of PDP sponsors and providers regarding the drug management program for at-risk beneficiaries described in this paragraph, including education—

''(i) provided by medicare administrative contractors through the improper payment outreach and education program described in section 1874A(h); and

''(ii) through current education efforts (such as State health insurance assistance programs described in subsection (a)(1)(A) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note)) and materials directed toward such enrollees.''.

(2) INFORMATION FOR CONSUMERS.—Section 1860D–4(a)(1)(B) of the Social Security Act (42

U.S.C. 1395w–104(a)(1)(B)) is amended by adding at the end the following:

"(v) The drug management program for at-risk beneficiaries under subsection (c)(5).".

(b) UTILIZATION MANAGEMENT PROGRAMS.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)), as amended by subsection (a) and section 8, is further amended—

(1) in paragraph (1), by inserting after subparagraph (D) the following new subparagraph:

"(E) A utilization management tool to prevent drug abuse (as described in paragraph (6)(A)).''; and

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

"(6) UTILIZATION MANAGEMENT TOOL TO PREVENT DRUG ABUSE.—

"(A) IN GENERAL.—A tool described in this paragraph is any of the following:

"(i) A utilization tool designed to prevent the abuse of frequently abused drugs by individuals and to prevent the diversion of such drugs at pharmacies.

''(ii) Retrospective utilization review to identify—

''(I) individuals that receive frequently abused drugs at a frequency or in amounts that are not clinically appropriate; and

''(II) providers of services or suppliers that may facilitate the abuse or diversion of frequently abused drugs by beneficiaries.

''(iii) Consultation with the Contractor described in subparagraph (B) to verify if an individual enrolling in a prescription drug plan offered by a PDP sponsor has been previously identified by another PDP sponsor as an individual described in clause (ii)(I).

''(B) REPORTING.—A PDP sponsor offering a prescription drug plan in a State shall submit to the Secretary and the Medicare drug integrity contractor with which the Secretary has entered into a contract under section 1893 with respect to such State a report, on a monthly basis, containing information on—

''(i) any provider of services or supplier described in subparagraph (A)(ii)(II) that is identified by such plan sponsor during the 30-day period before such report is submitted; and

''(ii) the name and prescription records of individuals described in paragraph (5)(C).''.

(c) EXPANDING ACTIVITIES OF MEDICARE DRUG INTEGRITY CONTRACTORS (MEDICS).—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(j) EXPANDING ACTIVITIES OF MEDICARE DRUG INTEGRITY CONTRACTORS (MEDICS).—

''(1) ACCESS TO INFORMATION.—Under contracts entered into under this section with Medicare drug integrity contractors, the Secretary shall authorize such contractors to directly accept prescription and necessary medical records from entities such as pharmacies, prescription drug plans, and physicians with respect to an individual in order for such contractors to provide information relevant to the determination of whether such individual is an at-risk beneficiary for prescription drug abuse, as defined in section 1860D–4(c)(5)(C).

''(2) REQUIREMENT FOR ACKNOWLEDGMENT OF REFERRALS.—If a PDP sponsor refers information to a contractor described in paragraph (1) in order for such contractor to assist in the determination described in such paragraph, the contractor shall—

''(A) acknowledge to the PDP sponsor receipt of the referral; and

''(B) in the case that any PDP sponsor contacts the contractor requesting to know the determination by the contractor of whether or not an individual has been determined to be an individual described such paragraph, shall inform such PDP sponsor of such determination on a date that is not later than 15 days after the date on which the PDP sponsor contacts the contractor.

''(3) MAKING DATA AVAILABLE TO OTHER ENTITIESSECT.—

''(A) IN GENERAL.—For purposes of carrying out this subsection, subject to subparagraph (B), the Secretary shall authorize MEDICs to respond to requests for information from PDP sponsors, State prescription drug monitoring programs, and other entities delegated by

PDP sponsors using available programs and systems in the effort to prevent fraud, waste, and abuse.

''(B) HIPAA COMPLIANT INFORMATION ONLY.—Information may only be disclosed by a MEDIC under subparagraph (A) if the disclosure of such information is permitted under the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).''.

(d) TREATMENT OF CERTAIN COMPLAINTS FOR PURPOSES OF QUALITY OR PERFORMANCE ASSESSMENT.—Section 1860D–42 of the Social Security Act (42 U.S.C. 1395w–152) is amended by adding at the end the following new subsection:

''(d) TREATMENT OF CERTAIN COMPLAINTS FOR PURPOSES OF QUALITY OR PERFORMANCE ASSESSMENT.—In conducting a quality or performance assessment of a PDP sponsor, the Secretary shall develop or utilize existing screening methods for reviewing and considering complaints that are received from enrollees in a prescription drug plan offered by such PDP sponsor and that are complaints regarding the lack of access by the

individual to prescription drugs due to a drug management program for at-risk beneficiaries.''.

(e) GAO STUDIES AND REPORTS.—

(1) STUDIES.—The Comptroller General of the United States shall conduct a study on each of the following:

(A) The implementation of the amendments made by this section.

(B) The effectiveness of the at-risk beneficiaries for prescription drug abuse drug management programs authorized by section 1860D–4(c)(5) of the Social Security Act (42 U.S.C. 1395w–10(c)(5)), as added by subsection (a)(1), including an analysis of—

(i) the impediments, if any, that impair the ability of individuals described in subparagraph (C) of such section 1860D–4(c)(5) to access clinically appropriate levels of prescription drugs; and

(ii) the types of—

(I) individuals who, in the implementation of such section, are determined to be individuals described in such subparagraph; and

(II) prescribers and pharmacies that are selected under subparagraph (D) of such section.

(2) REPORTS.—Not later than January 1, 2016, the Comptroller General of the United States shall begin work, with respect to each study described in paragraph (1), on a report that describes the result of such study. Upon the completion of each such report, such Comptroller General shall submit the report to each of the committees described in paragraph (3).

(3) COMMITTEES DESCRIBED.—The committees described in this paragraph are the following:

(A) The Committee on Ways and Means of the House of Representatives.

(B) The Committee on Energy and Commerce of the House of Representatives.

(C) The Committee on Finance of the Senate.

(D) The Committee on Health, Education, Labor, and Pensions of the Senate.

(E) The Special Committee on Aging of the Senate.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to prescription drug plans for plan years beginning on or after January 1, 2017.

(2) STAKEHOLDER MEETINGS PRIOR TO EFFECTIVE DATE.—

(A) IN GENERAL.—Not later than January 1, 2016, the Secretary shall convene stakeholders, including individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title of such Act, advocacy groups representing such individuals, clinicians, plan sponsors, and entities delegated by plan sponsors, for input regarding the topics described in subparagraph (B).

(B) TOPICS DESCRIBED.— The topics described in this subparagraph are the topics of—

(i) ensuring affordability and accessibility to prescription drugs for enrollees in prescription drug plans of PDP sponsors who are at-risk beneficiaries for prescription drug abuse (as defined in paragraph (5)(C) of section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–10(c)));

(ii) the use of an expedited appeals process under which such an enrollee may appeal an identification of such enrollee as an at-risk beneficiary for prescription drug abuse under such paragraph (similar to the processes established under the Medicare Advantage program under part C of title XVIII of the Social Security Act that allow an automatic escalation to external review of claims submitted under such part);

(iii) the types of enrollees that should be treated as exempted individuals, as described in clause (ii) of such paragraph;

(iv) the manner in which terms and definitions in paragraph (5) of such section 1860D–4(c) should be applied, such as the use of clinical appropriateness in determining whether an enrollee is an at-risk beneficiary for prescription drug abuse as defined in subparagraph (C) of such paragraph (5);

(v) the information to be included in the notices described in subparagraph (B) of such section and the standardization of such notices; and

(vi) with respect to a PDP sponsor that establishes a drug management program for at-risk beneficiaries under such paragraph (5), the responsibilities of such PDP sponsor with respect to the implementation of such program.

(C) RULEMAKING.—The Secretary shall promulgate regulations based on the input gathered pursuant to subparagraph (A).

SEC. 13. GUIDANCE ON APPLICATION OF COMMON RULE TO CLINICAL DATA REGISTRIES.

Not later than one year after the date of the enactment of this section, the Secretary of Health and Human Services shall issue a clarification or modification with respect to the application of subpart A of part 46 of title 45, Code of Federal Regulations, governing the protection of human subjects in research (and commonly known as the ''Common Rule''), to activities, including quality improvement activities, involving clinical data registries, including entities that are qualified clinical data registries pursuant to section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)).

SEC. 14. ELIMINATING CERTAIN CIVIL MONEY PENALTIES; GAINSHARING STUDY AND REPORT.

(a) ELIMINATING CIVIL MONEY PENALTIES FOR INDUCEMENTS TO PHYSICIANS TO LIMIT SERVICES THAT ARE NOT MEDICALLY NECESSARY.—

(1) IN GENERAL.—Section 1128A(b)(1) of the Social Security Act (42 U.S.C. 1320a–7a(b)(1)) is amended by inserting ''medically necessary'' after ''reduce or limit''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to payments made on or after the date of the enactment of this Act.

(b) GAINSHARING STUDY AND REPORT.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall submit to Congress a report with options for amending existing fraud and abuse laws in, and regulations related to, titles XI and XVIII of the Social Security Act (42 U.S.C. 301 et seq.), through exceptions, safe harbors, or other narrowly targeted provisions, to permit gainsharing arrangements that otherwise would be subject to the civil money penalties described in paragraphs (1) and (2) of section 1128A(b) of such Act (42 U.S.C. 1320a–7a(b)), or similar arrangements between physicians and hospitals, and that improve

care while reducing waste and increasing efficiency. The report shall—

(1) consider whether such provisions should apply to ownership interests, compensation arrangements, or other relationships;

(2) describe how the recommendations address accountability, transparency, and quality, including how best to limit inducements to stint on care, discharge patients prematurely, or otherwise reduce or limit medically necessary care; and

(3) consider whether a portion of any savings generated by such arrangements (as compared to an historical benchmark or other metric specified by the Secretary to determine the impact of delivery and payment system changes under such title XVIII on expenditures made under such title) should accrue to the Medicare program under title XVIII of the Social Security Act.

SEC. 15. MODIFICATION OF MEDICARE HOME HEALTH SURETY BOND CONDITION OF PARTICIPATION REQUIREMENT.

Section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)) is amended to read as follows:

''(7) provides the Secretary with a surety bond—

''(A) in a form specified by the Secretary and in an amount that is not less than the minimum of $50,000; and

''(B) that the Secretary determines is commensurate with the volume of payments to the home health agency; and''.

SEC. 16. OVERSIGHT OF MEDICARE COVERAGE OF MANUAL MANIPULATION OF THE SPINE TO CORRECT SUBLUXATION.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(z) MEDICAL REVIEW OF SPINAL SUBLUXATION SERVICES.—

''(1) IN GENERAL.—The Secretary shall implement a process for the medical review (as described in paragraph (2)) of treatment by a chiropractor described in section 1861(r)(5) by means of manual manipulation of the spine to correct a subluxation (as described in such section) of an individual who is enrolled under this part and apply such process to such services furnished on or after January 1, 2017, focusing on services such as—

''(A) services furnished by a such a chiropractor whose pattern of billing is aberrant compared to peers; and

''(B) services furnished by such a chiropractor who, in a prior period, has a services denial percentage in the 85th percentile or greater, taking into consideration the extent that service denials are overturned on appeal.

''(2) MEDICAL REVIEW.—

''(A) PRIOR AUTHORIZATION MEDICAL REVIEW.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall use prior authorization medical review for services described in paragraph (1) that are furnished to an individual by a chiropractor described in section 1861(r)(5) that are part of an episode of treatment that includes more than 12 services. For purposes of the preceding sentence, an episode of treatment shall be determined by the underlying cause that justifies the need for services, such as a diagnosis code.

''(ii) ENDING APPLICATION OF PRIOR AUTHORIZATION MEDICAL REVIEW.—The

Secretary shall end the application of prior authorization medical review under clause (i) to services described in paragraph (1) by such a chiropractor if the Secretary determines that the chiropractor has a low denial rate under such prior authorization medical review. The Secretary may subsequently reapply prior authorization medical review to such chiropractor if the Secretary determines it to be appropriate and the chiropractor has, in the time period subsequent to the determination by the Secretary of a low denial rate with respect to the chiropractor, furnished such services described in paragraph (1).

''(iii) EARLY REQUEST FOR PRIOR AUTHORIZATION REVIEW PERMITTED.—Nothing in this subsection shall be construed to prevent such a chiropractor from requesting prior authorization for services described in paragraph (1) that are to be furnished to an individual before the chiropractor furnishes the twelfth such service to such individual for an episode of treatment.

"(B) TYPE OF REVIEW.—The Secretary may use pre-payment review or post-payment review of services described in section 1861(r)(5) that are not subject to prior authorization medical review under subparagraph (A).

"(C) RELATIONSHIP TO LAW ENFORCEMENT ACTIVITIES.—The Secretary may determine that medical review under this subsection does not apply in the case where potential fraud may be involved.

"(3) NO PAYMENT WITHOUT PRIOR AUTHORIZATION.—With respect to a service described in paragraph (1) for which prior authorization medical review under this subsection applies, the following shall apply:

"(A) PRIOR AUTHORIZATION DETERMINATION.—The Secretary shall make a determination, prior to the service being furnished, of whether the service would or would not meet the applicable requirements of section 1862(a)(1)(A).

"(B) DENIAL OF PAYMENT.—Subject to paragraph (5), no payment may be made under this part for the service unless the Secretary determines pursuant to subparagraph (A) that

the service would meet the applicable requirements of such section 1862(a)(1)(A).

''(4) SUBMISSION OF INFORMATION.—A chiropractor described in section 1861(r)(5) may submit the information necessary for medical review by fax, by mail, or by electronic means. The Secretary shall make available the electronic means described in the preceding sentence as soon as practicable.

''(5) TIMELINESS.—If the Secretary does not make a prior authorization determination under paragraph (3)(A) within 14 business days of the date of the receipt of medical documentation needed to make such determination, paragraph (3)(B) shall not apply.

''(6) APPLICATION OF LIMITATION ON BENEFICIARY LIABILITY.—Where payment may not be made as a result of the application of paragraph (2)(B), section 1879 shall apply in the same manner as such section applies to a denial that is made by reason of section 1862(a)(1).

''(7) REVIEW BY CONTRACTORS.—The medical review described in paragraph (2) may be conducted by medicare administrative contractors pursuant to section 1874A(a)(4)(G) or by any other contractor

determined appropriate by the Secretary that is not a recovery audit contractor.

''(8) MULTIPLE SERVICES.—The Secretary shall, where practicable, apply the medical review under this subsection in a manner so as to allow an individual described in paragraph (1) to obtain, at a single time rather than on a service-by-service basis, an authorization in accordance with paragraph (3)(A) for multiple services.

''(9) CONSTRUCTION.—With respect to a service described in paragraph (1) that has been affirmed by medical review under this subsection, nothing in this subsection shall be construed to preclude the subsequent denial of a claim for such service that does not meet other applicable requirements under this Act.

''(10) IMPLEMENTATION.—

''(A) AUTHORITY.—The Secretary may implement the provisions of this subsection by interim final rule with comment period.

''(B) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to medical review under this subsection.''.

(b) IMPROVING DOCUMENTATION OF SERVICES.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with stakeholders (including the American Chiropractic Association) and representatives of medicare administrative contractors (as defined in section 1874A(a)(3)(A) of the Social Security Act (42 U.S.C. 1395kk–1(a)(3)(A))), develop educational and training programs to improve the ability of chiropractors to provide documentation to the Secretary of services described in section 1861(r)(5) in a manner that demonstrates that such services are, in accordance with section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)), reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

(2) TIMING.—The Secretary shall make the educational and training programs described in paragraph (1) publicly available not later than January 1, 2016.

(3) FUNDING.—The Secretary shall use funds made available under section 1893(h)(10) of the Social Security Act (42 U.S.C. 1395ddd(h)(10)), as added by section 6, to carry out this subsection.

(c) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of the process for medical review of services furnished as part of a treatment by means of manual manipulation of the spine to correct a subluxation implemented under subsection (z) of section 1833 of the Social Security Act (42 U.S.C. 1395l), as added by subsection (a). Such study shall include an analysis of—

(A) aggregate data on—

(i) the number of individuals, chiropractors, and claims for services subject to such review; and

(ii) the number of reviews conducted under such section; and

(B) the outcomes of such reviews.

(2) REPORT.—Not later than four years after the date of enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), including recommendations for such legislation and administrative action with respect to the process for medical review implemented under subsection (z) of section 1833 of the Social Security Act (42

U.S.C. 1395l) as the Comptroller General determines appropriate.

SEC. 17. LIMITING PAYMENT AMOUNT UNDER MEDICARE PROGRAM FOR VACUUM ERECTION SYSTEMS.

(a) INCLUSION IN PROGRAM.—Section 1847(a)(2) of the Social Security Act (42 U.S.C. 1395w–3(a)(2)) is amended by adding at the end the following new subparagraph:

"(D) VACUUM ERECTION SYSTEMS.—Vacuum erection systems covered as prosthetic devices described in section 1861(s)(8) for which payment would otherwise be made under section 1834(h).".

(b) NATIONAL MAIL ORDER PROGRAM.—Section 1847(a)(1)(D) of the Social Security Act (42 U.S.C. 1395w–3(a)(1)(D)) is amended by adding at the end the following new clause:

"(iv) NATIONAL MAIL ORDER PROGRAM FOR VACUUM ERECTION SYSTEMS.—The Secretary shall phase in a national mail order program under this section for vacuum erection systems described in paragraph (2)(D). The first round of competition for such program shall occur in 2016, with contracts taking effect after the com-

petition is completed. Chapter 35 of title 44, United States Code (commonly referred to as the 'Paperwork Reduction Act of 1995') shall not apply to the first round competition for such program.''.

SEC. 18. NATIONAL EXPANSION OF PRIOR AUTHORIZATION MODEL FOR REPETITIVE SCHEDULED NON-EMERGENT AMBULANCE TRANSPORT.

(a) INITIAL EXPANSION.—

(1) IN GENERAL.—In implementing the model described in paragraph (2) proposed to be tested under subsection (b) of section 1115A of the Social Security Act (42 U.S.C. 1315a), the Secretary of Health and Human Services shall revise the testing under subsection (b) of such section to cover, effective January 1, 2016, States located in medicare administrative contractor (MAC) regions L and 11 (consisting of Delaware, the District of Columbia, Maryland, New Jersey, Pennsylvania, North Carolina, South Carolina, West Virginia, and Virginia).

(2) MODEL DESCRIBED.—The model described in this paragraph is the testing of a model of prior authorization for repetitive scheduled non-emergent ambulance transport proposed to be carried out in New Jersey, Pennsylvania, and South Carolina.

(3) FUNDING.—The Secretary shall allocate funds made available under section 1115A(f)(1)(B) of the Social Security Act (42 U.S.C. 1315a(f)(1)(B)) to carry out this subsection.

(b) NATIONAL EXPANSION.—Section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) is amended by adding at the end the following new paragraph:

''(16) PRIOR AUTHORIZATION FOR REPETITIVE SCHEDULED NON-EMERGENCY AMBULANCE TRANSPORTS.—

''(A) IN GENERAL.—Beginning January 1, 2017, the Secretary shall apply the prior authorization program described in subparagraph (B) to all States.

''(B) PROGRAM DESCRIBED.—The prior authorization program described in this subparagraph is a prior authorization program for repetitive scheduled ambulance services consisting of non-emergency basic life support services involving transport of an individual furnished other than on an emergency basis. In carrying out the program, the Secretary shall determine in advance of the provision of items and services related to the provision of such an ambulance service whether payment for such

items or services may not be made because the item or service is not covered or because of the application of section 1862(a)(1).

''(C) IMPLEMENTATION.—The program described in subparagraph (B) shall be implemented in a manner that is consistent with the terms and conditions for the testing of a model of prior authorization for repetitive scheduled non-emergent ambulance transport proposed by the Centers for Medicare & Medicaid Services to be implemented in New Jersey, Pennsylvania, and South Carolina under section 1115A.

''(D) FUNDING.—The Secretary shall use funds made available under section 1893(h)(10) to carry out this paragraph.''.

SEC. 19. REPEALING DUPLICATIVE MEDICARE SECONDARY PAYOR PROVISION.

(a) IN GENERAL.—Section 1862(b)(5) of the Social Security Act (42 U.S.C. 1395y(b)(5)) is amended by inserting at the end the following new subparagraph:

''(E) END DATE.—The provisions of this paragraph shall not apply to information required to be provided on or after July 1, 2016.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to information required to be provided on or after January 1, 2016.

SEC. 20. PLAN FOR EXPANDING DATA IN ANNUAL CERT REPORT.

Not later than March 25, 2015, the Secretary of Health and Human Services shall submit to the Committee on Finance of the Senate, and to the Committees on Energy and Commerce and on Ways and Means of the House of Representatives—

(1) a plan for including, in the annual report of the Comprehensive Error Rate Testing (CERT) program, data on services (or groupings of services) (other than medical visits) paid under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) where the fee schedule amount is in excess of 250 dollars and where the error rate is in excess of 20 percent; and

(2) to the extent practicable by such date, specific examples of services described in paragraph (1).

SEC. 21. RULE OF CONSTRUCTION.

Except as explicitly provided in this Act, nothing in this Act, including the amendments made by this Act, shall be construed as preventing the use of notice and com-

ment rulemaking in the implementation of the provisions of, and the amendments made by, this Act.