§ 1395kkk. Repealed. Pub. L. 115–123, div. E, title XI, § 52001(a), Feb. 9, 2018, 132 Stat. 298

Section, Aug. 14, 1935, ch. 531, title XVIII, § 1899A, as added and amended Pub. L. 111–148, title III, § 3403(a)(1), title X, § 10320(a), Mar. 23, 2010, 124 Stat. 489, 949, established the Independent Payment Advisory Board.

CHANGE OF NAME

Pub. L. 111–148, title X, § 10320(b), Mar. 23, 2010, 124 Stat. 952, which provided that any reference in the provisions of, or amendments made by, section 3403 of Pub. L. 111–148 (enacting this section and section 1395kkk–1 of this title and amending section 1395b–6 of this title and section 207 of Title 18, Crimes and Criminal Procedure) to the ''Independent Medicare Advisory Board'' be deemed to be a reference to the ''Independent Payment Advisory Board'', was repealed by Pub. L. 115–123, div. E, title XI, § 52001(b)(4), Feb. 9, 2018, 132 Stat. 298.

CONSTRUCTION

Pub. L. 111–148, title X, § 10320(c), Mar. 23, 2010, 124 Stat. 952, which provided that nothing in the amendments made by section 10320 of Pub. L. 111–148 precluded the Independent Medicare Advisory Board (renamed the Independent Payment Advisory Board) from solely using data from public or private sources to carry out former subsection (f)(3)(B) of this section, was repealed by Pub. L. 115–123, div. E, title XI, § 52001(b)(5), Feb. 9, 2018, 132 Stat. 298.

§ 1395kkk–1. Repealed. Pub. L. 115–123, div. E, title XI, § 52001(b)(2), Feb. 9, 2018, 132 Stat. 298

Section, Pub. L. 111–148, title III, § 3403(b), Mar. 23, 2010, 124 Stat. 506, related to GAO study and report on determination and implementation of payment and coverage policies under the Medicare program.

§ 1395*lll*. Standardized post-acute care (PAC) assessment data for quality, payment, and discharge planning

(a) Requirement for standardized assessment data

(1) In general

The Secretary shall—

(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—

(i) standardized patient assessment data in accordance with subsection (b);

(ii) data on quality measures under subsection (c)(1); and

(iii) data on resource use and other measures under subsection (d)(1);

(B) require data described in subparagraph (A) to be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions, in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes; and

(C) in accordance with subsections (b)(1) and (c)(2), modify PAC assessment instruments (as defined in paragraph (2)(B)) applicable to post-acute care providers to—

(i) provide for the submission of standardized patient assessment data under this subchapter with respect to such providers; and

(ii) enable comparison of such assessment data across all such providers to whom such data are applicable.

(2) Definitions

For purposes of this section:

(A) Post-acute care (PAC) provider

The terms ''post-acute care provider'' and ''PAC provider'' mean—

(i) a home health agency;

(ii) a skilled nursing facility;

(iii) an inpatient rehabilitation facility; and

(iv) a long-term care hospital (other than a hospital classified under section 1395ww(d)(1)(B)(vi) of this title).

(B) PAC assessment instrument

The term ''PAC assessment instrument'' means—

(i) in the case of home health agencies, the instrument used for purposes of reporting and assessment with respect to the Outcome and Assessment Information Set (OASIS), as described in sections 484.55 and 484.250 of title 42, the Code of Federal Regulations, or any successor regulation, or any other instrument used with respect to home health agencies for such purposes;

(ii) in the case of skilled nursing facilities, the resident's assessment under section 1395i–3(b)(3) of this title;

(iii) in the case of inpatient rehabilitation facilities, any Medicare beneficiary assessment instrument established by the Secretary for purposes of section 1395ww(j) of this title; and

(iv) in the case of long-term care hospitals, the Medicare beneficiary assessment instrument used with respect to such hospitals for the collection of data elements necessary to calculate quality measures as described in the August 18, 2011, Federal Register (76 Fed. Reg. 51754–51755), including for purposes of section 1395ww(m)(5)(C) of this title, or any other instrument used with respect to such hospitals for assessment purposes.

(C) Applicable reporting provision

The term ''applicable reporting provision'' means—

(i) for home health agencies, section 1395fff(b)(3)(B)(v) of this title;

(ii) for skilled nursing facilities, section 1395yy(e)(6) of this title;

(iii) for inpatient rehabilitation facilities, section 1395ww(j)(7) of this title; and

(iv) for long-term care hospitals, section 1395ww(m)(5) of this title.

(D) PAC payment system

The term ''PAC payment system'' means—

(i) with respect to a home health agency, the prospective payment system under section 1395fff of this title;

(ii) with respect to a skilled nursing facility, the prospective payment system under section 1395yy(e) of this title;

(iii) with respect to an inpatient rehabilitation facility, the prospective pay-

ment system under section 1395ww(j) of this title; and

(iv) with respect to a long-term care hospital, the prospective payment system under section 1395ww(m) of this title.

(E) Specified application date

The term ''specified application date'' means the following:

(i) Quality measures

In the case of quality measures under subsection (c)(1)—

(I) with respect to the domain described in subsection (c)(1)(A) (relating to functional status, cognitive function, and changes in function and cognitive function)—

(aa) for PAC providers described in clauses (ii) and (iii) of paragraph (2)(A), October 1, 2016;

(bb) for PAC providers described in clause (iv) of such paragraph, October 1, 2018; and

(cc) for PAC providers described in clause (i) of such paragraph, January 1, 2019;

(II) with respect to the domain described in subsection (c)(1)(B) (relating to skin integrity and changes in skin integrity)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2017;

(III) with respect to the domain described in subsection (c)(1)(C) (relating to medication reconciliation)—

(aa) for PAC providers described in clause (i) of such paragraph, January 1, 2017; and

(bb) for PAC providers described in clauses (ii), (iii), and (iv) of such paragraph, October 1, 2018;

(IV) with respect to the domain described in subsection (c)(1)(D) (relating to incidence of major falls)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2019; and

(V) with respect to the domain described in subsection (c)(1)(E) (relating to accurately communicating the existence of and providing for the transfer of health information and care preferences)—

(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2018; and

(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2019.

(ii) Resource use and other measures

In the case of resource use and other measures under subsection (d)(1)—

(I) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

(II) for PAC providers described in clause (i) of such paragraph, January 1, 2017.

(F) Medicare beneficiary

The term ''Medicare beneficiary'' means an individual entitled to benefits under part A or, as appropriate, enrolled for benefits under part B.

(b) Standardized patient assessment data

(1) Requirement for reporting assessment data

(A) In general

Beginning not later than October 1, 2018, for PAC providers described in clauses (ii), (iii), and (iv) of subsection (a)(2)(A) and January 1, 2019, for PAC providers described in clause (i) of such subsection, the Secretary shall require PAC providers to submit to the Secretary, under the applicable reporting provisions and through the use of PAC assessment instruments, the standardized patient assessment data described in subparagraph (B). The Secretary shall require such data be submitted with respect to admission and discharge of an individual (and may be submitted more frequently as the Secretary deems appropriate).

(B) Standardized patient assessment data described

For purposes of subparagraph (A), the standardized patient assessment data described in this subparagraph is data required for at least the quality measures described in subsection (c)(1) and that is with respect to the following categories:

(i) Functional status, such as mobility and self care at admission to a PAC provider and before discharge from a PAC provider.

(ii) Cognitive function, such as ability to express ideas and to understand, and mental status, such as depression and dementia.

(iii) Special services, treatments, and interventions, such as need for ventilator use, dialysis, chemotherapy, central line placement, and total parenteral nutrition.

(iv) Medical conditions and co-morbidities, such as diabetes, congestive heart failure, and pressure ulcers.

(v) Impairments, such as incontinence and an impaired ability to hear, see, or swallow.

(vi) Other categories deemed necessary and appropriate by the Secretary.

(2) Alignment of claims data with standardized patient assessment data

To the extent practicable, not later than October 1, 2018, for PAC providers described in clauses (ii), (iii), and (iv) of subsection (a)(2)(A), and January 1, 2019, for PAC providers described in clause (i) of such subsection, the Secretary shall match claims data with assessment data pursuant to this section for purposes of assessing prior service use and concurrent service use, such as antecedent

hospital or PAC provider use, and may use such matched data for such other uses as the Secretary determines appropriate.

(3) Replacement of certain existing data

In the case of patient assessment data being used with respect to a PAC assessment instrument that duplicates or overlaps with standardized patient assessment data within a category described in paragraph (1), the Secretary shall, as soon as practicable, revise or replace such existing data with the standardized data.

(4) Clarification

Standardized patient assessment data submitted pursuant to this subsection shall not be used to require individuals to be provided post-acute care by a specific type of PAC provider in order for such care to be eligible for payment under this subchapter.

(c) Quality measures

(1) Requirement for reporting quality measures

Not later than the specified application date, as applicable to measures and PAC providers, the Secretary shall specify quality measures on which PAC providers are required under the applicable reporting provisions to submit standardized patient assessment data described in subsection (b)(1) and other necessary data specified by the Secretary. Such measures shall be with respect to at least the following domains:

(A) Functional status, cognitive function, and changes in function and cognitive function.

(B) Skin integrity and changes in skin integrity.

(C) Medication reconciliation.

(D) Incidence of major falls.

(E) Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions—

(i) from a hospital or critical access hospital to another applicable setting, including a PAC provider or the home of the individual; or

(ii) from a PAC provider to another applicable setting, including a different PAC provider, a hospital, a critical access hospital, or the home of the individual.

(2) Reporting through PAC assessment instruments

(A) In general

To the extent possible, the Secretary shall require such reporting by a PAC provider of quality measures under paragraph (1) through the use of a PAC assessment instrument and shall modify such PAC assessment instrument as necessary to enable the use of such instrument with respect to such quality measures.

(B) Limitation

The Secretary may not make significant modifications to a PAC assessment instrument more than once per calendar year or fiscal year, as applicable, unless the Secretary publishes in the Federal Register a justification for such significant modification.

(3) Adjustments

(A) In general

The Secretary shall consider applying adjustments to the quality measures under this subsection taking into consideration the studies under section 2(d) of the IMPACT Act of 2014.

(B) Risk adjustment

Such quality measures shall be risk adjusted, as determined appropriate by the Secretary.

(d) Resource use and other measures

(1) Requirement for resource use and other measures

Not later than the specified application date, as applicable to measures and PAC providers, the Secretary shall specify resource use and other measures on which PAC providers are required under the applicable reporting provisions to submit any necessary data specified by the Secretary, which may include standardized assessment data in addition to claims data. Such measures shall be with respect to at least the following domains:

(A) Resource use measures, including total estimated Medicare spending per beneficiary.

(B) Discharge to community.

(C) Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates.

(2) Aligning methodology adjustments for resource use measures

(A) Period of time

With respect to the period of time used for calculating measures under paragraph (1)(A), the Secretary shall, to the extent the Secretary determines appropriate, align resource use with the methodology used for purposes of section 1395ww(*o*)(2)(B)(ii) of this title.

(B) Geographic and other adjustments

The Secretary shall standardize measures with respect to the domain described in paragraph (1)(A) for geographic payment rate differences and payment differentials (and other adjustments, as applicable) consistent with the methodology published in the Federal Register on August 18, 2011 (76 Fed. Reg. 51624 through 51626), or any subsequent modifications made to the methodology.

(C) Medicare spending per beneficiary

The Secretary shall adjust, as appropriate, measures with respect to the domain described in paragraph (1)(A) for the factors applied under section 1395ww(*o*)(2)(B)(ii) of this title.

(3) Adjustments

(A) In general

The Secretary shall consider applying adjustments to the resource use and other

measures specified under this subsection with respect to the domain described in paragraph (1)(A), taking into consideration the studies under section 2(d) of the IMPACT Act of 2014.

(B) Risk adjustment

Such resource use and other measures shall be risk adjusted, as determined appropriate by the Secretary.

(e) Measurement implementation phases; selection of quality measures and resource use and other measures

(1) Measurement implementation phases

In the case of quality measures specified under subsection (c)(1) and resource use and other measures specified under subsection (d)(1), the provisions of this section shall be implemented in accordance with the following phases:

(A) Initial implementation phase

The initial implementation phase, with respect to such a measure, shall, in accordance with subsections (c) and (d), as applicable, consist of—

(i) measure specification, including informing the public of the measure's numerator, denominator, exclusions, and any other aspects the Secretary determines necessary;

(ii) data collection, including, in the case of quality measures, requiring PAC providers to report data elements needed to calculate such a measure; and

(iii) data analysis, including, in the case of resource use and other measures, the use of claims data to calculate such a measure.

(B) Second implementation phase

The second implementation phase, with respect to such a measure, shall consist of the provision of feedback reports to PAC providers, in accordance with subsection (f).

(C) Third implementation phase

The third implementation phase, with respect to such a measure, shall consist of public reporting of PAC providers' performance on such measure in accordance with subsection (g).

(2) Consensus-based entity

(A) In general

Subject to subparagraph (B), each measure specified by the Secretary under this section shall be endorsed by the entity with a contract under section 1395aaa(a) of this title.

(B) Exception

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1395aaa(a) of this title, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(3) Treatment of application of pre-rulemaking process (measure applications partnership process)

(A) In general

Subject to subparagraph (B), the provisions of section 1395aaa–1 of this title shall apply in the case of a quality measure specified under subsection (c) or a resource use or other measure specified under subsection (d).

(B) Exceptions

(i) Expedited procedures

For purposes of satisfying subparagraph (A), the Secretary may use expedited procedures, such as ad-hoc reviews, as necessary, in the case of a quality measure specified under subsection (c) or a resource use or other measure specified in subsection (d) required with respect to data submissions under the applicable reporting provisions during the 1-year period before the specified application date applicable to such a measure and provider involved.

(ii) Option to waive provisions

The Secretary may waive the application of the provisions of section 1395aaa–1 of this title in the case of a quality measure or resource use or other measure described in clause (i), if the application of such provisions (including through the use of an expedited procedure described in such clause) would result in the inability of the Secretary to satisfy any deadline specified in this section with respect to such measure.

(f) Feedback reports to PAC providers

(1) In general

Beginning one year after the specified application date, as applicable to PAC providers and quality measures and resource use and other measures under this section, the Secretary shall provide confidential feedback reports to such PAC providers on the performance of such providers with respect to such measures required under the applicable provisions.

(2) Frequency

To the extent feasible, the Secretary shall provide feedback reports described in paragraph (1) not less frequently than on a quarterly basis. Notwithstanding the previous sentence, with respect to measures described in such paragraph that are reported on an annual basis, the Secretary may provide such feedback reports on an annual basis.

(g) Public reporting of PAC provider performance

(1) In general

Subject to the succeeding paragraphs of this subsection, the Secretary shall provide for public reporting of PAC provider performance on quality measures under subsection (c)(1) and the resource use and other measures under subsection (d)(1), including by establishing procedures for making available to the public information regarding the performance of individual PAC providers with respect to such measures.

(2) Opportunity to review

The procedures under paragraph (1) shall ensure, including through a process consistent with the process applied under section 1395ww(b)(3)(B)(viii)(VII) of this title for similar purposes, that a PAC provider has the opportunity to review and submit corrections to the data and information that is to be made public with respect to the provider prior to such data being made public.

(3) Timing

Such procedures shall provide that the data and information described in paragraph (1), with respect to a measure and PAC provider, is made publicly available beginning not later than two years after the specified application date applicable to such a measure and provider.

(4) Coordination with existing programs

Such procedures shall provide that data and information described in paragraph (1) with respect to quality measures and resource use and other measures under subsections (c)(1) and (d)(1) shall be made publicly available consistent with the following provisions:

(A) In the case of home health agencies, section 1395fff(b)(3)(B)(v)(III) of this title.

(B) In the case of skilled nursing facilities, sections 1395i–3(i) and 1396r(i) of this title.

(C) In the case of inpatient rehabilitation facilities, section 1395ww(j)(7)(E) of this title.

(D) In the case of long-term care hospitals, section 1395ww(m)(5)(E) of this title.

(h) Removing, suspending, or adding measures

(1) In general

The Secretary may remove, suspend, or add a quality measure or resource use or other measure described in subsection (c)(1) or (d)(1), so long as, subject to paragraph (2), the Secretary publishes in the Federal Register (with a notice and comment period) a justification for such removal, suspension, or addition.

(2) Exception

In the case of such a quality measure or resource use or other measure for which there is a reason to believe that the continued collection of such measure raises potential safety concerns or would cause other unintended consequences, the Secretary may promptly suspend or remove such measure and satisfy paragraph (1) by publishing in the Federal Register a justification for such suspension or removal in the next rulemaking cycle following such suspension or removal.

(i) Use of standardized assessment data, quality measures, and resource use and other measures to inform discharge planning and incorporate patient preference

(1) In general

Not later than January 1, 2016, and periodically thereafter (but not less frequently than once every 5 years), the Secretary shall promulgate regulations to modify conditions of participation and subsequent interpretive guidance applicable to PAC providers, hospitals, and critical access hospitals. Such regulations and interpretive guidance shall require such providers to take into account quality, resource use, and other measures under the applicable reporting provisions (which, as available, shall include measures specified under subsections (c) and (d), and other relevant measures) in the discharge planning process. Specifically, such regulations and interpretive guidance shall address the settings to which a patient may be discharged in order to assist subsection (d) hospitals, critical access hospitals, hospitals described in section 1395ww(d)(1)(B)(v) of this title, PAC providers, patients, and families of such patients with discharge planning from inpatient settings, including such hospitals, and from PAC provider settings. In addition, such regulations and interpretive guidance shall include procedures to address—

(A) treatment preferences of patients; and

(B) goals of care of patients.

(2) Discharge planning

All requirements applied pursuant to paragraph (1) shall be used to help inform and mandate the discharge planning process.

(3) Clarification

Such regulations shall not require an individual to be provided post-acute care by a specific type of PAC provider in order for such care to be eligible for payment under this subchapter.

(j) Stakeholder input

Before the initial rulemaking process to implement this section, the Secretary shall allow for stakeholder input, such as through town halls, open door forums, and mail-box submissions.

(k) Funding

For purposes of carrying out this section, the Secretary shall provide for the transfer to the Centers for Medicare & Medicaid Services Program Management Account, from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund under section 1395t of this title, in such proportion as the Secretary determines appropriate, of $130,000,000. Fifty percent of such amount shall be available on October 6, 2014, and fifty percent of such amount shall be equally proportioned for each of fiscal years 2015 through 2019. Such sums shall remain available until expended.

(*l*) Limitation

There shall be no administrative or judicial review under sections 1395ff and 1395*oo* of this title or otherwise of the specification of standardized patient assessment data required, the determination of measures, and the systems to report such standardized data under this section.

(m) Non-application of Paperwork Reduction Act

Chapter 35 of title 44 (commonly referred to as the ''Paperwork Reduction Act of 1995'') shall not apply to this section and the sections referenced in subsection (a)(2)(B) that require modification in order to achieve the standardization of patient assessment data.

(Aug. 14, 1935, ch. 531, title XVIII, § 1899B, as added Pub. L. 113–185, § 2(a), Oct. 6, 2014, 128 Stat. 1952; amended Pub. L. 114–255, div. C, title XV, § 15008(d)(1), Dec. 13, 2016, 130 Stat. 1321.)

REFERENCES IN TEXT

Section 2(d) of the IMPACT Act of 2014, referred to in subsecs. (c)(3)(A) and (d)(3)(A), is section 2(d) of Pub. L. 113–185, which is set out as a note under this section.

AMENDMENTS

2016—Subsec. (a)(2)(A)(iv). Pub. L. 114–255 substituted ''1395ww(d)(1)(B)(vi)'' for ''1395ww(d)(1)(B)(iv)(II)''.

PERMITTING OCCUPATIONAL THERAPISTS TO CONDUCT THE INITIAL ASSESSMENT VISIT AND COMPLETE THE COMPREHENSIVE ASSESSMENT WITH RESPECT TO CERTAIN REHABILITATION SERVICES FOR HOME HEALTH AGENCIES UNDER THE MEDICARE PROGRAM

Pub. L. 116–260, div. CC, title I, § 115, Dec. 27, 2020, 134 Stat. 2948, provided that: ''Not later than January 1, 2022, the Secretary of Health and Human Services shall revise subsections (a)(2) and (b)(3) of section 484.55 of title 42, Code of Federal Regulations, or a successor regulation, to permit an occupational therapist to conduct the initial assessment visit and to complete the comprehensive assessment (as such terms are described in such subsections, respectively) for home health services for an individual under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) if the home health plan of care for such individual—

''(1) does not initially include skilled nursing care;

''(2) includes occupational therapy; and

''(3) includes physical therapy or speech language pathology.''

IMPROVING PAYMENT ACCURACY UNDER THE PAC PAYMENT SYSTEMS AND OTHER MEDICARE PAYMENT SYSTEMS

Pub. L. 113–185, § 2(d), Oct. 6, 2014, 128 Stat. 1966, provided that:

''(1) STUDIES AND REPORTS OF EFFECT OF CERTAIN INFORMATION ON QUALITY AND RESOURCE USE.—

''(A) STUDY USING EXISTING MEDICARE DATA.—

''(i) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the 'Secretary') shall conduct a study that examines the effect of individuals' socioeconomic status on quality measures and resource use and other measures for individuals under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (such as to recognize that less healthy individuals may require more intensive interventions). The study shall use information collected on such individuals in carrying out such program, such as urban and rural location, eligibility for Medicaid under title XIX of such Act (42 U.S.C. 1396 et seq.) (recognizing and accounting for varying Medicaid eligibility across States), and eligibility for benefits under the supplemental security income (SSI) program. The Secretary shall carry out this paragraph acting through the Assistant Secretary for Planning and Evaluation.

''(ii) REPORT.—Not later than 2 years after the date of the enactment of this Act [Oct. 6, 2014], the Secretary shall submit to Congress a report on the study conducted under clause (i).

''(B) STUDY USING OTHER DATA.—

''(i) STUDY.—The Secretary shall conduct a study that examines the impact of risk factors, such as those described in section 1848(p)(3) of the Social Security Act (42 U.S.C. 1395w–4(p)(3)), race, health literacy, limited English proficiency (LEP), and Medicare beneficiary activation, on quality measures and resource use and other measures under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). In conducting such study the Secretary may use existing Federal data and collect such additional data as may be necessary to complete the study.

''(ii) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under clause (i).

''(C) EXAMINATION OF DATA IN CONDUCTING STUDIES.—In conducting the studies under subparagraphs (A) and (B), the Secretary shall examine what non-Medicare data sets, such as data from the American Community Survey (ACS), can be useful in conducting the types of studies under such paragraphs and how such data sets that are identified as useful can be coordinated with Medicare administrative data in order to improve the overall data set available to do such studies and for the administration of the Medicare program.

''(D) RECOMMENDATIONS TO ACCOUNT FOR INFORMATION IN PAYMENT ADJUSTMENT MECHANISMS.—If the studies conducted under subparagraphs (A) and (B) find a relationship between the factors examined in the studies and quality measures and resource use and other measures, then the Secretary shall also provide recommendations for how the Centers for Medicare & Medicaid Services should—

''(i) obtain access to the necessary data (if such data is not already being collected) on such factors, including recommendations on how to address barriers to the Centers in accessing such data; and

''(ii) account for such factors—

''(I) in quality measures, resource use measures, and other measures under title XVIII of the Social Security Act (including such measures specified under subsections (c) and (d) of section 1899B of such Act [42 U.S.C. 1395*lll*], as added by subsection (a)); and

''(II) in determining payment adjustments based on such measures in other applicable provisions of such title.

''(E) FUNDING.—There are hereby appropriated to the Secretary from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) (in proportions determined appropriate by the Secretary) to carry out this paragraph $6,000,000, to remain available until expended.

''(2) CMS ACTIVITIES.—

''(A) IN GENERAL.—Taking into account the relevant studies conducted and recommendations made in reports under paragraph (1) and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual's health status and other factors—

''(i) assess appropriate adjustments to quality measures, resource use measures, and other measures under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (including measures specified in subsections (c) and (d) of section 1899B of such Act, as added by subsection (a)); and

''(ii) assess and implement appropriate adjustments to payments under such title based on measures described in clause (i).

''(B) ACCESSING DATA.—The Secretary shall collect or otherwise obtain access to the data necessary to carry out this paragraph through existing and new data sources.

''(C) PERIODIC ANALYSES.—The Secretary shall carry out periodic analyses, at least every 3 years, based on the factors referred to in subparagraph (A) so as to monitor changes in possible relationships.

''(D) FUNDING.—There are hereby appropriated to the Secretary from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) (in proportions determined

appropriate by the Secretary) to carry out this paragraph $10,000,000, to remain available until expended.

''(3) STRATEGIC PLAN FOR ACCESSING RACE AND ETHNICITY DATA.—Not later than 18 months after the date of the enactment of this Act [Oct. 6, 2014], the Secretary shall develop and report to Congress on a strategic plan for collecting or otherwise accessing data on race and ethnicity for purposes of specifying quality measures and resource use and other measures under subsections (c) and (d) of section 1899B of the Social Security Act, as added by subsection (a), and, as the Secretary determines appropriate, other similar provisions of, including payment adjustments under, title XVIII of such Act (42 U.S.C. 1395 et seq.).''

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§ 1396. Medicaid and CHIP Payment and Access Commission

(a) Establishment

There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as ''MACPAC'').

(b) Duties

(1) Review of access policies for all States and annual reports

MACPAC shall—

(A) review policies of the Medicaid program established under this subchapter (in this section referred to as ''Medicaid'') and the State Children's Health Insurance Program established under subchapter XXI (in this section referred to as ''CHIP'') affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) Specific topics to be reviewed

Specifically, MACPAC shall review and assess the following:

(A) Medicaid and CHIP payment policies

Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) Eligibility policies

Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) Enrollment and retention processes

Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) Coverage policies

Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) Quality of care

Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) Interaction of Medicaid and CHIP payment policies with health care delivery generally

The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this subchapter or subchapter XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) Interactions with Medicare and Medicaid

Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under subchapter XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.

(H) Other access policies

The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) Recommendations and reports of State-specific data

MACPAC shall—