AMENDMENT TO H.R. 2810

OFFERED BY MR. BURGESS OF TEXAS AND MR. PALLONE OF NEW JERSEY

[Page and line numbers to SGR-EC__intro, as posted by the Energy and Commerce Committee]

Page 7, strike lines 4 through 10, and insert the following:

''(D) ELIGIBLE PROFESSIONAL ORGANIZATION.—The term 'eligible professional organization' means a professional organization as defined by nationally recognized multispecialty boards of certification or equivalent certification boards.''.

Page 9, beginning on line 8, strike ''the American Board of Medical Specialties'' and insert ''nationally recognized multispecialty boards of certification''.

Page 29, line 1, strike ''update'' and insert ''quality''.

Page 30, line 1, insert ''beginning not later than 6 months after the first day of the first performance period,'' after ''quarterly,''.

Page 36, line 26, insert ''testing and'' before ''evaluation''.

Page 37, line 4, insert ''tested and'' before ''evaluated''.

Page 37, lines 22, strike ''As soon as practicable'' and all that follows through page 38, line 2, and insert ''The Secretary shall enter into the first contract under subparagraph (A) to be in effect January 1, 2019.''.

Page 39, strike lines 4 through 21, and insert the following:

''(A) RECOMMENDATIONS TO SECRETARY.—

''(i) IN GENERAL.—Under the process under subsection (b), the APM contracting entity shall at least quarterly recommend, in accordance with clause (ii), to the Secretary—

''(I) Alternative Payment Models submitted under subsection (c) to be tested and evaluated through a demonstration program under subsection (e); and

''(II) Alternative Payment Models submitted under subsection (c) to

be implemented under subsection (f) without testing and evaluation through such a demonstration program.

Such a recommendation under subclause (I) may be made with respect to a model for which a waiver would be required under paragraph (2). Any reference in this subsection to an Alternative Payment Model under this clause is a reference to such model as may be modified under clause (iii).

''(ii) REQUIREMENTS.—In recommending an Alternative Payment Model under clause (i), each of the following shall apply:

''(I) The APM contracting entity may recommend an Alternative Payment Model under clause (i)(I) only if the entity determines that the model satisfies the criteria described in subparagraph (B), including the criteria described in subparagraph (B)(iv).

''(II) The APM contracting entity may recommend an Alternative

Payment Model under clause (i)(II) only if the entity determines that the model satisfies the criteria described in subparagraph (C), including the criteria described in subparagraph (C)(iii).

''(III) The APM contracting entity shall include with the recommended Alternative Payment Model recommendations for rules of coordination described in clause (v).

''(iii) MODIFICATIONS BY APM CONTRACTING ENTITY.—For purposes of this subparagraph, to the extent necessary to meet the applicable requirements of clause (ii), the APM contracting entity may modify an Alternative Payment Model submitted under subsection (c) to ensure that the model would—

''(I) reduce spending under this title without reducing the quality of care; or

''(II) improve the quality of care without increasing spending under this title.

''(iv) FORMS OF MODIFICATIONS.—Such a modification under clause (iii) may include one or more of the following:

''(I) A change to the payment arrangement under which eligible professionals participating in such model would be paid for covered professional services furnished under such model.

''(II) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that the requirement described in subclause (I) or (II) is satisfied.

''(III) A change to the rules of coordination described in clause (v).

''(IV) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

''(V) Such other change as the contracting entity may specify.

"(v) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

"(I) IN GENERAL.—Rules of coordination described in this clause for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible professional is treated as having a payment arrangement under a particular model.

"(II) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that might be covered under more than one payment arrangement or under section 1848(d)(16).

"(III) APPLICATION TO NON-APM PAYMENT.—In applying such rules of coordination for purposes of section 1848(d)(16), an eligible professional shall not be treated as having a payment arrangement in effect under

such a model for any covered professional services not treated as furnished under the model.''.

Page 39, beginning on line 23, strike ''The APM'' and all that follows through page 40, line 3, and insert the following: ''For purposes of subparagraph (A)(ii)(I), the criteria described in this subparagraph, with respect to an Alternative Payment Model, are each of the following:''.

Page 40, line 9, strike ''clause (v)'' and insert ''clause (iv)''.

Page 40, line 10, strike ''(ii) (I)'' and insert ''(ii)(I)''.

Page 40, line 18, strike ''meaningful evaluation'' insert ''a meaningful evaluation of the likely effect of expanding the demonstration''.

Page 41, line 2, strike ''meaningful evaluation'' insert ''a meaningful evaluation of the likely effect of expanding the demonstration''.

Page 41, line 3, insert ''tested and'' before ''evaluated''.

Page 41, strike lines 8 through 16.

Page 41, line 17, strike ''(v)'' and insert ''(iv)''.

Page 41, line 19, strike ''potential'' and insert ''significant likelihood''.

Page 41, beginning on line 23, strike ''for individuals participating under such APM''.

Page 41, beginning on line 25, strike ''for such individuals''.

Page 42, line 2, insert ''and'' after the semicolon.

Page 42, strike lines 3 and 4.

Page 42, line 5, strike ''(III)'' and insert ''(II)''.

Page 42, line 6, strike ''quality of care'' and insert ''overall quality of patient care''.

Page 42, line 8, strike ''who participate under such mode''.

Page 42, line 9, strike ''(vi)'' and insert ''(v)''.

Page 42, amend lines 11 through 14 to read as follows:

''(I) that specifies the items and services covered under the arrangement and specifies rules of coordination described in subparagraph (A)(v)

between the items and services covered under the arrangement and other items and services not covered under the arrangement;''.

Page 43, beginning on line 8, strike ''The APM'' and all that follows through line 14, and insert the following: ''For purposes of subparagraph (A)(ii)(II), the criteria described in this subparagraph, with respect to an Alternative Payment Model, is that the model has already been tested and evaluated for a sufficient enough period and through such testing and evaluation the model was shown—''.

Page 43, line 17, strike ''clause (vi) of subparagraph (B);'' and insert ''clause (v) of subparagraph (B); and''.

Page 43, strike lines 18 through 20.

Page 43, line 21, strike ''(iii)(I) to reduce'' and insert ''(ii)(I) to have reduced''.

Page 43, line 24, strike ''improve'' and insert ''to have improved''.

Page 43, line 25, insert ''such'' before ''spending''.

Page 44, line 5, strike ''an entity, the APM contracting entity'' and insert ''the APM contracting entity, the APM contracting entity''.

Page 44, line 7, strike ''such entity'' and insert ''the model submitter''.

Page 45, line 4, strike ''(A)(i)'' and insert ''(A)(i)(I)''.

Page 45, beginning on line 11, strike ''subparagraph (A)(ii), including any such models that require a waiver under paragraph (2),'' and insert ''subparagraph (A)(i)(II)''.

Page 45, line 17, strike ''For any year'' and insert ''(iii) EXPLANATION FOR NO RECOMMENDATIONS.—For any year''.

Page 45, line 18, insert ''entity'' after ''contracting''.

Page 45, line 19, strike ''(A)'' and insert ''(A)(i)''.

Page 45, after line 23, insert the following:

''(iv) JUSTIFICATIONS FOR RECOMMENDATIONS.—In submitting data and analyses under subclause (I) or (II) of clause (ii) with respect to a model, the APM contracting entity shall include a specific explanation of how the model would (and recommendations for ensuring that the model will) meet the criteria de-

scribed in subparagraph (B) or (C), respectively.

''(v) CONFIRMATION OF SPENDING ESTIMATES BY CMS CHIEF ACTUARY.—For each Alternative Payment Model described in subclause (I) or (II) of clause (ii), the Chief Actuary of the Centers for Medicare & Medicaid Services shall submit to the Secretary a determination of whether or not the Chief Actuary confirms that the model satisfies the criterion described in subparagraph (B)(iv)(I) or (C)(ii), respectively.''.

Page 46, line 6, insert ''solely'' after ''waiver''.

Page 46, line 7, insert ''tested and'' before ''evaluated''.

Page 46, beginning on line 8, strike ''(if described in clause (i) of such paragraph)''.

Page 46, line 10, strike ''90'' and insert ''180''.

Page 46, line 15, strike ''provided'' and insert ''approved''.

Page 46, line 22, strike ''participating entities'' and insert ''participating APM providers''.

Page 47, line 1, strike ''(3)'' and insert ''(4)''.

Page 47, beginning on line 3, strike ''(or a shorter period'' and all that follows through line 5.

Page 47, strike lines 6 through 15, and insert the following:

''(2) APPROVAL BY SECRETARY OF MODELS FOR DEMONSTRATION.—

''(A) IN GENERAL.—Not later than 180 days after the date of receipt of a submission under subsection (d)(1)(D)(ii), with respect to an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(I), the Secretary shall—

''(i) review the basis for such recommendation in order to assess, taking into account the determination of the Chief Actuary under subsection (d)(1)(D)(v) with respect to such model, if the model is significantly likely to—

''(I) reduce spending under this title without reducing the quality of care; or

''(II) improve the quality of care without increasing spending under this title;

''(ii) assess whether the model is significantly likely to result in participation under such model of a sufficient number of those eligible professionals for whom the model was designed consistent with clause (i) to be able to evaluate the likely effect of expanding the demonstration; and

''(iii) approve such model for a demonstration program under this subsection, including as modified under subparagraph (B), only if the Secretary determines—

''(I) the model is significantly likely to satisfy the criterion described in subclause (I) or (II) of clause (i);

''(II) the model is significantly likely to result in the participation of a sufficient number of eligible professionals described in clause (ii);

''(III) the model applies rules of coordination described in subparagraph (C) applicable to such model; and

''(IV) the model satisfies the criteria described in subsection (d)(1)(B).

The Secretary shall periodically make available a list of such models approved under clause (iii).

''(B) MODIFICATIONS BY SECRETARY.—

''(i) BEFORE APPROVAL.—For purposes of subparagraph (A), the Secretary may modify an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(I) to ensure that the model meets the requirements described in subparagraph (A)(iii). Such a modification may include one or more of the following:

''(I) A change to the payment arrangement under which eligible professionals participating in such model would be paid for covered professional services furnished under such model.

''(II) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that such requirements are satisfied.

''(III) A change to the rules of coordination described in subparagraph (C).

''(IV) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

''(V) Such other change as the Secretary may specify.

''(ii) TERMINATION OR MODIFICATION DURING DEMONSTRATION.—The Secretary shall terminate or modify the design and implementation of an Alternative Payment Model approved under subparagraph (A)(iii) for a demonstration program, after testing has begun, unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under this title, certifies) that the model is expected to continue to satisfy the requirements described in such paragraph relating to quality of care and reduced spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

''(C) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

''(i) IN GENERAL.—Rules of coordination described in this subparagraph for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible professional is treated as having a payment arrangement under a particular model.

''(ii) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that might be covered under more than one payment arrangement or under section 1848(d)(16).

''(iii) APPLICATION TO NON-APM PAYMENT.—In applying such rules for purposes of section 1848(d)(16), an eligible professional shall not be treated as having a payment arrangement in effect under

such a model for any covered professional services not treated as furnished under the model.''.

Page 47, line 16, strike ''PARTICIPATING ENTITIES.—To participate'' and insert''PARTICIPATING APM PROVIDERS—

''(A) IN GENERAL.—To participate''.

Page 47, line 19, strike ''a physician, practitioner, or other supplier'' and insert ''an eligible professional''.

Page 47, lines 22 and 23, strike ''a physician, practitioner, or supplier'' and insert ''an eligible professional''.

Page 48, line 1, strike ''shall be referred to'' and insert ''in this section is referred to''.

Page 48, after line 2, insert the following:

''(B) REQUIREMENTS.—The Secretary shall establish criteria for eligible professionals to enter into contracts under this paragraph for purposes of participation under a demonstration program with respect to an Alternative Payment Model. Such criteria shall ensure participation under such model of a sufficient number of eligible professionals for whom the model was

designed in order to satisfy the criterion described in paragraph (2)(A)(iii)(II).''.

Page 49, lines 3 and 4, strike ''participating entities'' and insert ''participating APM providers''.

Page 49, line 15, strike ''participating entities'' and insert ''participating APM providers''.

Page 51, line 8, strike ''program''.

Page 52, line 1, insert ''and as of the date of the enactment of this section'' after ''not otherwise appropriated''.

Page 52, line 6, strike ''transferred'' and insert ''appropriated''.

Page 52, line 11, strike ''participating entities'' and inserting ''participating APM providers''.

Page 53, line 1, insert ''APM'' before ''contracting entity''.

Page 53, strike line 13 and all that follows through page 55, line 2, and insert the following:

''(1) ASSESSMENT.—With respect to each Alternative Payment Model recommended under subsection (d)(1)(A)(i)(II) or (e)(4)(E)(ii)(I), the Secretary shall review the basis for such recommenda-

tion and assess and determine, in consultation with the Chief Actuary of the Centers for Medicare & Medicaid Services, whether the model is significantly likely to continue to result in meeting the criterion described in subsection (e)(2)(A)(iii)(I), with or without a modification described in paragraph (5).

''(2) IMPLEMENTATION THROUGH RULEMAKING.—

''(A) PUBLICATION OF NPRM.—If the Secretary determines that such a model is significantly likely to meet such criterion, the Secretary shall publish as part of the applicable physician fee schedule rulemaking process (specified in paragraph (3)) a notice of proposed rulemaking to implement such model, including as modified under paragraph (5).

''(B) COMMENTS BY MEDPAC.—Not later than 90 days after the date of issuance of such notice with respect to a model, the Medicare Payment Advisory Commission shall submit comments on the proposed rule for such model to Congress and to the Secretary. Such comments shall include an evaluation of the reports from the contracting entity and independent evaluation entity on such model regarding the

model's impact on expenditures and quality of care under this title.

''(C) FINAL RULE AND CONDITIONS.—The Secretary shall publish as part of the applicable physician fee schedule rulemaking process (specified in paragraph (3)) a final notice implementing such proposed rule, including as modified under paragraph (5), as an eligible APM only if—

''(i) the Secretary determines that such model is expected to—

''(I) reduce spending under this title without reducing the quality of care; or

''(II) improve the quality of patient care without increasing spending;

''(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such model would reduce (or would not result in any increase in) spending under this title;

''(iii) the Secretary determines that such model would not deny or limit the

coverage or provision of benefits under this title for applicable individuals; and

''(iv) the Secretary determines that the model is significantly likely to result in the participation of a sufficient number of appropriate eligible professionals for whom the model was designed in order to satisfy the criterion described in subsection (d)(2)(A)(iii)(II);

''(v) the Secretary determines that the model applies rules of coordination described in paragraph (6); and

''(vi) the Secretary determines that model meets such other criteria as the Secretary may determine.

''(3) APPLICABLE PHYSICIAN FEE SCHEDULE RULEMAKING PROCESS.—For purposes of paragraph (2), in the case of an Alternative Payment Model recommended under subsection (d)(1)(A)(ii) or (e)(4)(E)(ii)(I)—

''(A) on or before April 1 of a year, the applicable physician fee schedule rulemaking process is the process for publication by November 1 of that year of the fee schedule amounts under this section for the succeeding year; or

''(B) after April 1 of a year, the applicable physician fee schedule rulemaking process is the process for publication by November 1 of the following year of the fee schedule amounts under this section for the second succeeding year.''.

Page 54, line 16, strike ''(2)'' and insert ''(3)''.

Page 54, line 17, strike ''(1)'' and insert ''(2)''.

Page 54, line 21, and page 55, line 1, strike ''90 days'' and insert ''180 days''.

Page 55, line 2, insert a period at the end.

Page 55, line 3, strike ''(3)'' and insert ''(4)''.

Page 55, after line 9, insert the following:

''(5) MODIFICATIONS BY SECRETARY.—For purposes of this subsection, the Secretary may modify an Alternative Payment Model recommended under subsection (d)(1)(A)(i)(II) or (e)(4)(E)(ii)(I) to ensure that the model meets the requirements under paragraph (1)(B). Such a modification may include one or more of the following:

''(A) A change to the payment arrangement under which eligible professionals participating in such model would be paid for covered

professional services furnished under such model.

''(B) A change to the criteria for eligible professionals to be eligible to participate under such model in order to ensure that such requirements are satisfied.

''(C) A change to the rules of coordination described in paragraph (6).

''(D) The application of a withhold mechanism under the payment arrangement under which the distribution of withheld amounts is based on the success of the model in meeting spending reduction requirements.

''(E) Such other change as the Secretary may specify.

''(6) RULES OF COORDINATION FOR APPLICATION OF PAYMENT ARRANGEMENTS UNDER MODELS.—

''(A) IN GENERAL.—Rules of coordination described in this paragraph for an Alternative Payment Model shall be designed to determine, for purposes of applying subsection (a) and section 1848(d)(16), under what circumstances an eligible professional is treated as having a payment arrangement under a particular model.

''(B) NONDUPLICATION OF PAYMENT.—Such rules of coordination shall ensure coordination and nonduplication of payment of services that might be covered under more than one payment arrangement or under section 1848(d)(16).

''(C) APPLICATION TO NON-APM PAYMENT.—In applying such rules for purposes of section 1848(d)(16), an eligible professional shall not be treated as having a payment arrangement in effect under such a model for any covered professional services not treated as furnished under the model.''.

Page 57, after line 5, insert the following new subsection:

(d) ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.—

(1) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C. 1395w–4(e)) is amended by adding at the end the following new paragraph:

''(6) USE OF MSAS AS FEE SCHEDULE AREAS IN CALIFORNIA.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and not-

withstanding the previous provisions of this subsection, for services furnished on or after January 1, 2017, the fee schedule areas used for payment under this section applicable to California shall be the following:

''(i) Each Metropolitan Statistical Area (each in this paragraph referred to as an 'MSA'), as defined by the Director of the Office of Management and Budget as of December 31 of the previous year, shall be a fee schedule area.

''(ii) All areas not included in an MSA shall be treated as a single rest-of-State fee schedule area.

''(B) TRANSITION FOR MSAS PREVIOUSLY IN REST-OF-STATE PAYMENT LOCALITY OR IN LOCALITY 3.—

''(i) IN GENERAL.—For services furnished in California during a year beginning with 2017 and ending with 2021 in an MSA in a transition area (as defined in subparagraph (D)), subject to subparagraph (C), the geographic index values to be applied under this subsection for such

year shall be equal to the sum of the following:

"(I) CURRENT LAW COMPONENT.—The old weighting factor (described in clause (ii)) for such year multiplied by the geographic index values under this subsection for the fee schedule area that included such MSA that would have applied in such area (as estimated by the Secretary) if this paragraph did not apply.

"(II) MSA-BASED COMPONENT.—The MSA-based weighting factor (described in clause (iii)) for such year multiplied by the geographic index values computed for the fee schedule area under subparagraph (A) for the year (determined without regard to this subparagraph).

"(ii) OLD WEIGHTING FACTOR.—The old weighting factor described in this clause—

"(I) for 2017, is 5/6; and

"(II) for each succeeding year, is the old weighting factor described in

this clause for the previous year minus ⅙.

''(iii) MSA-BASED WEIGHTING FACTOR.—The MSA-based weighting factor described in this clause for a year is 1 minus the old weighting factor under clause (ii) for that year.

''(C) HOLD HARMLESS.—For services furnished in a transition area in California during a year beginning with 2017, the geographic index values to be applied under this subsection for such year shall not be less than the corresponding geographic index values that would have applied in such transition area (as estimated by the Secretary) if this paragraph did not apply.

''(D) TRANSITION AREA DEFINED.—In this paragraph, the term 'transition area' means each of the following fee schedule areas for 2013:

''(i) The rest-of-State payment locality.

''(ii) Payment locality 3.

''(E) REFERENCES TO FEE SCHEDULE AREAS.—Effective for services furnished on or

after January 1, 2017, for California, any reference in this section to a fee schedule area shall be deemed a reference to a fee schedule area established in accordance with this paragraph.''.

(2) CONFORMING AMENDMENT TO DEFINITION OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social Security Act (42 U.S.C. 1395w–4(j)(2)) is amended by striking ''The term'' and inserting ''Except as provided in subsection (e)(6)(D), the term''.

Page 57, line 12, insert ''paragraph (4)(B) and'' after ''notwithstanding''.

Page 57, line 17, insert ''non-public'' after ''additional''.

Page 57, lines 18 through 19, strike ''that such entity may'' and insert ''or''.

Page 57, line 20, insert ''such data to registered or authorized users and subscribers, including'' after ''sell''.

Page 57, line 20, insert '', for non-public use'' after ''suppliers''.

Page 58, line 17, strike ''for non-public use''.

Page 58, line 21, strike ''in order'' and insert ''for non-public use including''.

Page 59, line 7, insert ''and disseminating risk-adjusted, scientifically valid'' before ''analysis''.

Page 59, line 8, insert ''or patient safety, provided that any public reporting of identifiable provider data shall only be conducted with prior consent of such provider'' before the period.

Page 59, lines 17 through 18, strike ''applicable physician'' and insert ''applicable provider''.

Page 60, line 5, strike ''physician'' and insert ''provider''.

Page 60, line 9, strike ''PHYSICIAN'' and insert ''PROVIDER''.

Page 60, lines 10 through 11, strike ''applicable physician'' and insert ''applicable provider''.

Page 60, line 12, insert '' or a physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A))'' after ''1861(r)(1))''.

Page 61, line 5, strike ''PHYSICIAN'' and insert ''PROVIDER''.

Page 61, line 8, strike ''physician'' and insert ''provider''.

Page 62, line 17, insert ''on'' after ''report''.

Page 63, line 25, insert ''for 2019 and each subsequent year'' after ''a report''.

Page 64, line 6, strike '', as of such date,''.

Page 67, after line 3, insert the following:

(4) REPORT ON CLINICAL DECISION SUPPORT MECHANISMS.—Not later than one year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the extent to which clinical decision support mechanisms and other provider support tools could be used to further program objectives under section 1848 of the Social Security Act (42 U.S.C. 1395w–4)) and recommendation for how such mechanisms and tools should be so used.

Page 69, strike line 16 and all that follows through page 70, line 8, and insert the following:

''(M) ADJUSTMENTS FOR MISVALUED PHYSICIANS' SERVICES.—

''(i) IN GENERAL.—Only with respect to fee schedules established for 2016, 2017, and 2018 (and not for subsequent years), the Secretary shall—

''(I) identify, based on the data reported under paragraph (8) and

other relevant data, misvalued services for which adjustments to the relative values established under this paragraph would result in a reduction in expenditures under the fee schedule under this section, with respect to such year, of not more than 1 percent of the projected amount of expenditures under such fee schedule for such year; and

''(II) make such adjustments for each such year so as only to result in such a reduction for such year.

''(ii) NO EFFECT ON SUBSEQUENT YEARS.—A reduction under this subparagraph for a year shall not affect any reduction for any subsequent year.

''(iii) RULE OF CONSTRUCTION RELATING TO UNDERVALUED CODES.—Nothing in this subparagraph shall be construed as preventing the Secretary from increasing the relative values for codes that are undervalued.''.

Page 70, line 16, insert ''for fiscal years 2016, 2017, and 2018'' after ''subparagraph (M)''.

Page 70, after line 16, insert the following new paragraph:

(3) DISCLOSURE OF DATA USED TO ESTABLISH MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—The Secretary of Health and Human Services shall make publicly available the data used to establish the multiple procedure payment reduction policy to the professional component of imaging services in the final rule published in the Federal Register, v. 77, n. 222, November 16, 2012, pages 68891-69380 under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

Page 67, beginning on line 4, redesignate subsection (b) as subsection (e) and transfer such subsection (e), as amended, to the end of section 2 on page 57, after line 5.

Page 70, line 17, redesignate subsection (c) as subsection (b).

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