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(Original Signature of Member)

113TH CONGRESS
2D SESSION

H. R. _____

To amend the Social Security Act to extend Medicare payments to physicians and other provisions of the Medicare and Medicaid programs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

M__. _____ introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Social Security Act to extend Medicare payments to physicians and other provisions of the Medicare and Medicaid programs, 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 "_____Act of 2014".

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE EXTENDERS

Sec. 101. Physician payment update.
Sec. 102. Extension of work GPCI floor.
Sec. 103. Extension of therapy cap exceptions process.
Sec. 104. Extension of ambulance add-ons.
Sec. 105. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals.
Sec. 106. Extension of the Medicare-dependent hospital (MDH) program.
Sec. 107. Extension for specialized Medicare Advantage plans for special needs individuals.
Sec. 108. Extension of Medicare reasonable cost contracts.
Sec. 109. Extension of funding for quality measure endorsement, input, and selection.
Sec. 110. Extension of funding outreach and assistance for low-income programs.
Sec. 111. Extension of two-midnight rule.
Sec. 112. Technical changes to Medicare LTCH amendments.

TITLE II—OTHER HEALTH PROVISIONS

Sec. 201. Extension of the qualifying individual (QI) program.
Sec. 202. Temporary extension of transitional medical assistance (TMA).
Sec. 203. Extension of Medicaid and CHIP express lane option.
Sec. 204. Extension of special diabetes program for type I diabetes and for Indians.
Sec. 205. Extension of abstinence education.
Sec. 206. Extension of personal responsibility education program (PREP).
Sec. 207. Extension of funding for family-to-family health information centers.
Sec. 208. Extension of health workforce demonstration project for low-income individuals.
Sec. 209. Extension of maternal, infant, and early childhood home visiting programs.
Sec. 210. Pediatric quality measures.
Sec. 211. Delay of effective date for Medicaid amendments relating to beneficiary liability settlements.
Sec. 212. Delay in transition from ICD–9 TO ICD–10 code sets.
Sec. 213. Elimination of limitation on deductibles for employer-sponsored health plans.
Sec. 214. GAO report on the Children's Hospital Graduate Medical Education Program.
Sec. 215. Skilled nursing facility value-based purchasing.
Sec. 216. Improving Medicare policies for clinical diagnostic laboratory tests.
Sec. 217. Revisions under the Medicare ESRD prospective payment system.
Sec. 218. Quality incentives for computed tomography diagnostic imaging and promoting evidence-based care.
Sec. 219. Using funding from Transitional Fund for Sustainable Growth Rate (SGR) Reform.
Sec. 220. Ensuring accurate valuation of services under the physician fee schedule.
Sec. 221. Medicaid DSH.
Sec. 222. Realignment of the Medicare sequester for fiscal year 2024.
Sec. 223. Demonstration programs to improve community mental health services.

Sec. 224. Assisted outpatient treatment grant program for individuals with serious mental illness.
Sec. 225. Exclusion from PAYGO scorecards.

TITLE I—MEDICARE EXTENDERS

SEC. 101. PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended—

(1) in paragraph (15)—

(A) in the heading, by striking ''JANUARY THROUGH MARCH OF'';

(B) in subparagraph (A), by striking ''for the period beginning on January 1, 2014, and ending on March 31, 2014''; and

(C) in subparagraph (B)—

(i) in the heading, by striking ''REMAINING PORTION OF 2014 AND'' ; and

(ii) by striking ''the period beginning on April 1, 2014, and ending on December 31, 2014, and for''; and

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

''(16) UPDATE FOR JANUARY THROUGH MARCH OF 2015.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), (9)(B), (10)(B), (11)(B), (12)(B), (13)(B), (14)(B), and (15)(B), in lieu of the update to the single conversion factor es-

tablished in paragraph (1)(C) that would otherwise apply for 2015 for the period beginning on January 1, 2015, and ending on March 31, 2015, the update to the single conversion factor shall be 0.0 percent.

"(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR REMAINING PORTION OF 2015 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for the period beginning on April 1, 2015, and ending on December 31, 2015, and for 2016 and subsequent years as if subparagraph (A) had never applied.".

SEC. 102. EXTENSION OF WORK GPCI FLOOR.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking "April 1, 2014" and inserting "April 1, 2015".

SEC. 103. EXTENSION OF THERAPY CAP EXCEPTIONS PROCESS.

Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) is amended—

(1) in paragraph (5)(A), in the first sentence, by striking "March 31, 2014" and inserting "March 31, 2015"; and

(2) in paragraph (6)(A)—

(A) by striking ''March 31, 2014'' and inserting ''March 31, 2015''; and

(B) by striking ''2012, 2013, or the first three months of 2014'' and inserting ''2012, 2013, 2014, or the first three months of 2015''.

SEC. 104. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended by striking ''April 1, 2014'' and inserting ''April 1, 2015'' each place it appears.

(b) SUPER RURAL GROUND AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended, in the first sentence, by striking ''April 1, 2014'' and inserting ''April 1, 2015''.

SEC. 105. EXTENSION OF INCREASED INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR CERTAIN LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (B), in the matter preceding clause (i), by striking ''in the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years'' and inserting ''in

fiscal year 2015 (beginning on April 1, 2015), fiscal year 2016, and subsequent fiscal years''; (2) in subparagraph (C)(i), by striking ''fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before'' and inserting ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),'' each place it appears; and (3) in subparagraph (D), by striking ''fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before April 1, 2014,'' and inserting ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),''.

SEC. 106. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) IN GENERAL.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''April 1, 2014'' and inserting ''April 1, 2015''; and

(2) in clause (ii)(II), by striking ''April 1, 2014'' and inserting ''April 1, 2015''.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''April 1, 2014'' and inserting ''April 1, 2015''; and

(B) in clause (iv), by striking ''through fiscal year 2013 and the portion of fiscal year 2014 before April 1, 2014'' and inserting ''through fiscal year 2014 and the portion of fiscal year 2015 before April 1, 2015''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking ''through the first 2 quarters of fiscal year 2014'' and inserting ''through the first 2 quarters of fiscal year 2015''.

SEC. 107. EXTENSION FOR SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.

Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by striking ''2016'' and inserting ''2017''.

SEC. 108. EXTENSION OF MEDICARE REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the mat-

ter preceding subclause (I), by striking ''January 1, 2015'' and inserting ''January 1, 2016''.

SEC. 109. EXTENSION OF FUNDING FOR QUALITY MEASURE ENDORSEMENT, INPUT, AND SELECTION.

Section 1890(d) of the Social Security Act (42 U.S.C. 1395aaa(d)) is amended—

(1) by inserting ''(1)'' before ''For purposes''; and

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

''(2) For purposes of carrying out this section and section 1890A (other than subsections (e) and (f)), the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, to the Centers for Medicare & Medicaid Services Program Management Account of $12,500,000 for the first 6 months of fiscal year 2015. Amounts transferred under the preceding sentence shall remain available until expended.''.

SEC. 110. EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B) of section

119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note), as amended by section 3306 of the Patient Protection and Affordable Care Act Public Law 111–148), section 610 of the American Taxpayer Relief Act of 2012 (Public Law 112–240), and section 1110 of the Pathway for SGR Reform Act of 2013 (Public Law 113–67), is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) by striking clause (iv); and

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

''(iv) for fiscal year 2014, of $7,500,000; and

''(v) for the portion of fiscal year 2015 before April 1, 2015, of $3,750,000.''.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119, as so amended, is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) by striking clause (iv); and

(3) by inserting after clause (iii) the following new clauses:

''(iv) for fiscal year 2014, of $7,500,000; and

1 "(v) for the portion of fiscal year
2 2015 before April 1, 2015, of
3 $3,750,000.".
4 (c) ADDITIONAL FUNDING FOR AGING AND DIS-
5 ABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of
6 such section 119, as so amended, is amended—
7 (1) in clause (iii), by striking "and" at the end;
8 (2) by striking clause (iv); and
9 (3) by inserting after clause (iii) the following
10 new clauses:
11 "(iv) for fiscal year 2014, of
12 $5,000,000; and
13 "(v) for the portion of fiscal year
14 2015 before April 1, 2015, of
15 $2,500,000.".
16 (d) ADDITIONAL FUNDING FOR CONTRACT WITH
17 THE NATIONAL CENTER FOR BENEFITS AND OUTREACH
18 ENROLLMENT.—Subsection (d)(2) of such section 119, as
19 so amended, is amended—
20 (1) in clause (iii), by striking "and" at the end;
21 (2) by striking clause (iv); and
22 (3) by inserting after clause (iii) the following
23 new clauses:
24 "(iv) for fiscal year 2014, of
25 $5,000,000; and

1 ''(v) for the portion of fiscal year
2 2015 before April 1, 2015, of
3 $2,500,000.''.

4 **SEC. 111. EXTENSION OF TWO-MIDNIGHT RULE.**

5 The Secretary of Health and Human Services may
6 continue medical review activities described in the notice
7 entitled ''Selecting Hospital Claims for Patient Status Re-
8 views: Admissions On or After October 1, 2013'', posted
9 on the Internet website of the Centers for Medicare &
10 Medicaid Services, through the first 6 months of fiscal
11 year 2015 for such additional hospital claims as the Sec-
12 retary determines appropriate.

13 **SEC. 112. TECHNICAL CHANGES TO MEDICARE LTCH**
14 **AMENDMENTS.**

15 (a) IN GENERAL.—Subclauses (I) and (II) of section
16 1886(m)(6)(C)(iv)) of the Social Security Act (42 U.S.C.
17 1395ww(m)(6)(C)(iv)) are each amended by striking ''dis-
18 charges'' and inserting ''Medicare fee-for-service dis-
19 charges''.

20 (b) MMSEA CORRECTION.—Section 114(d) of the
21 Medicare, Medicaid, and SCHIP Extension Act of 2007
22 (42 U.S.C. 1395ww note), as amended by sections 3106(b)
23 and 10312(b) of Public Law 111–148 and by section
24 1206(b)(2) of the Pathway for SGR Reform Act of 2013
25 (division B of Public Law 113–67), is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''January 1, 2015,'' and inserting ''on the date of the enactment of paragraph (7) of this subsection'';

(2) in paragraph (6), by striking ''January 1, 2015,'' and inserting ''on the date of the enactment of paragraph (7) of this subsection''; and

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

''(7) ADDITIONAL EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—The moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that—

''(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of enactment of this paragraph;

''(B) has a binding written agreement as of the date of the enactment of this paragraph with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before such date of enactment, at least

1 10 percent of the estimated cost of the project
2 (or, if less, $2,500,000); or
3 ''(C) has obtained an approved certificate
4 of need in a State where one is required on or
5 before such date of enactment.''.
6 (c) ADDITIONAL AMENDMENTS.—Section 1206(a) of
7 the Pathway for SGR Reform Act of 2013 (division B of
8 Public Law 113–67) is amended—
9 (1) in paragraph (2)(A), by striking ''Assess-
10 ment'' and inserting ''Advisory''; and
11 (2) in paragraph (3)(B), by striking ''shall not
12 apply to a hospital that is classified as of December
13 10, 2013, as a subsection (d) hospital (as defined in
14 section 1886(d)(1)(B) of the Social Security Act, 42
15 U.S.C. 1395ww(d)(1)(B))'' and inserting ''shall only
16 apply to a hospital that is classified as of December
17 10, 2013, as a long-term care hospital (as defined
18 in section 1861(ccc) of the Social Security Act, 42
19 U.S.C. 1395x(ccc))''.
20 (d) EFFECTIVE DATE.—The amendments made by
21 this section are effective as of the date of the enactment
22 of this Act.

TITLE II—OTHER HEALTH PROVISIONS

SEC. 201. EXTENSION OF THE QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking ''March 2014'' and inserting ''March 2015''.

(b) EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g) of the Social Security Act (42 U.S.C. 1396u–3(g)) is amended—

(1) in paragraph (2)—

(A) in subparagraph (T), by striking ''and'' at the end;

(B) in subparagraph (U)—

(i) by striking ''March 31, 2014'' and inserting ''September 30, 2014''; and

(ii) by striking ''$200,000,000.'' and inserting ''$485,000,000;''; and

(C) by adding at the end the following new subparagraphs:

''(V) for the period that begins on October 1, 2014, and ends on December 31, 2014, the total allocation amount is $300,000,000; and

"(W) for the period that begins on January 1, 2015, and ends on March 31, 2015, the total allocation amount is $250,000,000."; and

(2) in paragraph (3), in the matter preceding subparagraph (A), by striking "or (T)" and inserting "(T), or (V)".

SEC. 202. TEMPORARY EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA).

Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)) are each amended by striking "March 31, 2014" and inserting "March 31, 2015".

SEC. 203. EXTENSION OF MEDICAID AND CHIP EXPRESS LANE OPTION.

Section 1902(e)(13)(I) of the Social Security Act (42 U.S.C. 1396a(e)(13)(I)) is amended by striking "September 30, 2014" and inserting "September 30, 2015".

SEC. 204. EXTENSION OF SPECIAL DIABETES PROGRAM FOR TYPE I DIABETES AND FOR INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by striking "2014" and inserting "2015".

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2)(C) of the Public Health Service Act

(42 U.S.C. 254c–3(c)(2)(C)) is amended by striking ''2014'' and inserting ''2015''.

SEC. 205. EXTENSION OF ABSTINENCE EDUCATION.

Subsections (a) and (d) of section 510 of the Social Security Act (42 U.S.C. 710) are each amended by striking ''2014'' and inserting ''2015''.

SEC. 206. EXTENSION OF PERSONAL RESPONSIBILITY EDUCATION PROGRAM (PREP).

Section 513 of the Social Security Act (42 U.S.C. 713) is amended—

(1) in paragraphs (1)(A) and (4)(A) of subsection (a), by striking ''2014'' and inserting ''2015'' each place it appears;

(2) in subsection (a)(4)(B)(i), by striking ''and 2014'' and inserting ''2014, and 2015''; and

(3) in subsection (f), by striking ''2014'' and inserting ''2015''.

SEC. 207. EXTENSION OF FUNDING FOR FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

Section 501(c)(1)(A) of the Social Security Act (42 U.S.C. 701(c)(1)(A)) is amended—

(1) in clause (iii), by striking at the end ''and'';

(2) in clause (iv), by striking the period at the end and inserting a semicolon and by moving the margin to align with the margin for clause (iii); and

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

''(v) $2,500,000 for the portion of fiscal year 2014 on or after April 1, 2014; and

''(vi) $2,500,000 for the portion of fiscal year 2015 before April 1, 2015.''.

SEC. 208. EXTENSION OF HEALTH WORKFORCE DEMONSTRATION PROJECT FOR LOW-INCOME INDIVIDUALS.

Section 2008(c)(1) of the Social Security Act (42 U.S.C. 1397g(c)(1)) is amended by striking ''2014'' and inserting ''2015''.

SEC. 209. EXTENSION OF MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Section 511(j) of the Social Security Act (42 U.S.C. 711(j)) is amended—

(1) in paragraph (1)—

(A) by striking ''and'' at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(F) for the period beginning on October 1, 2014, and ending on March 31, 2015, an

1 amount equal to the amount provided in sub-
2 paragraph (E).''; and
3 (2) in paragraphs (2) and (3), by inserting ''(or
4 portion of a fiscal year)'' after ''for a fiscal year''
5 each place it appears.

6 **SEC. 210. PEDIATRIC QUALITY MEASURES.**

7 (a) CONTINUATION OF FUNDING FOR PEDIATRIC
8 QUALITY MEASURES FOR IMPROVING THE QUALITY OF
9 CHILDREN'S HEALTH CARE.—Section 1139B(e) of the
10 Social Security Act (42 U.S.C. 1320b–9b(e)) is amended
11 by adding at the end the following: '' 'Of the funds appro-
12 priated under this subsection, not less than $15,000,000
13 shall be used to carry out section 1139A(b).''.

14 (b) ELIMINATION OF RESTRICTION ON MEDICAID
15 QUALITY MEASUREMENT PROGRAM.—Section
16 1139B(b)(5)(A) of the Social Security Act (42 U.S.C.
17 1320b–9b(b)(5)(A)) is amended by striking ''The aggre-
18 gate amount awarded by the Secretary for grants and con-
19 tracts for the development, testing, and validation of
20 emerging and innovative evidence-based measures under
21 such program shall equal the aggregate amount awarded
22 by the Secretary for grants under section
23 1139A(b)(4)(A)''.

SEC. 211. DELAY OF EFFECTIVE DATE FOR MEDICAID AMENDMENTS RELATING TO BENEFICIARY LIABILITY SETTLEMENTS.

Effective as if included in the enactment of the Bipartisan Budget Act of 2013 (Public Law 113–67), section 202(c) of such Act is amended by striking ''October 1, 2014'' and inserting ''October 1, 2016''.

SEC. 212. DELAY IN TRANSITION FROM ICD–9 TO ICD–10 CODE SETS.

The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations.

SEC. 213. ELIMINATION OF LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED HEALTH PLANS.

(a) IN GENERAL.—Section 1302(c) of the Patient Protection and Affordable Care Act (Public Law 111–148; 42 U.S.C. 18022(c)) is amended—

(1) by striking paragraph (2); and

(2) in paragraph (4)(A), by striking ''paragraphs (1)(B)(i) and (2)(B)(i)'' and inserting ''paragraph (1)(B)(i)''.

(b) CONFORMING AMENDMENT.—Section 2707(b) of the Public Health Service Act (42 U.S.C. 300gg–6(b)) is

1 amended by striking ''paragraphs (1) and (2)'' and insert-
2 ing ''paragraph (1)''.
3 (c) EFFECTIVE DATE.—The amendments made by
4 this Act shall be effective as if included in the enactment
5 of the Patient Protection and Affordable Care Act (Public
6 Law 111–148).

7 **SEC. 214. GAO REPORT ON THE CHILDREN'S HOSPITAL**
8 **GRADUATE MEDICAL EDUCATION PROGRAM.**

9 (a) IN GENERAL.—In the case that the Children's
10 Hospital GME Support Reauthorization Act of 2013 is en-
11 acted into law, the Comptroller General of the United
12 States shall, not later than November 30, 2017, conduct
13 an independent evaluation, and submit to the appropriate
14 committees of Congress a report, concerning the imple-
15 mentation of section 340E(h) of the Public Health Service
16 Act, as added by section 3 of the Children's Hospital GME
17 Support Reauthorization Act of 2013.
18 (b) CONTENT.—The report described in subsection
19 (a) shall review and assess each of the following, with re-
20 spect to hospitals receiving payments under such section
21 340E(h) during the period of fiscal years 2015 through
22 2017:
23 (1) The number and type of such hospitals that
24 applied for such payments.

1 (2) The number and type of such hospitals re-
2 ceiving such payments.
3 (3) The amount of such payments awarded to
4 such hospitals.
5 (4) How such hospitals used such payments.
6 (5) The impact of such payments on—
7 (A) the number of pediatric providers; and
8 (B) health care needs of children.

9 **SEC. 215. SKILLED NURSING FACILITY VALUE-BASED PUR-**
10 **CHASING.**

11 (a) IN GENERAL.—Section 1888 of the Social Secu-
12 rity Act (42 U.S.C. 1395yy) is amended by adding at the
13 end the following new subsection:
14 ''(g) SKILLED NURSING FACILITY READMISSION
15 MEASURE.—
16 ''(1) READMISSION MEASURE.—Not later than
17 October 1, 2015, the Secretary shall specify a skilled
18 nursing facility all-cause all-condition hospital read-
19 mission measure (or any successor to such a meas-
20 ure).
21 ''(2) RESOURCE USE MEASURE.—Not later than
22 October 1, 2016, the Secretary shall specify a meas-
23 ure to reflect an all-condition risk-adjusted poten-
24 tially preventable hospital readmission rate for
25 skilled nursing facilities.

1 "(3) MEASURE ADJUSTMENTS.—When speci-
2 fying the measures under paragraphs (1) and (2),
3 the Secretary shall devise a methodology to achieve
4 a high level of reliability and validity, especially for
5 skilled nursing facilities with a low volume of re-
6 admissions.

7 "(4) PRE-RULEMAKING PROCESS (MEASURE AP-
8 PLICATION PARTNERSHIP PROCESS).—The applica-
9 tion of the provisions of section 1890A shall be op-
10 tional in the case of a measure specified under para-
11 graph (1) and a measure specified under paragraph
12 (2).

13 "(5) FEEDBACK REPORTS TO SKILLED NURS-
14 ING FACILITIES.—Beginning October 1, 2016, and
15 every quarter thereafter, the Secretary shall provide
16 confidential feedback reports to skilled nursing fa-
17 cilities on the performance of such facilities with re-
18 spect to a measure specified under paragraph (1) or
19 (2).

20 "(6) PUBLIC REPORTING OF SKILLED NURSING
21 FACILITIES.—

22 "(A) IN GENERAL.—Subject to subpara-
23 graphs (B) and (C), the Secretary shall estab-
24 lish procedures for making available to the pub-
25 lic by posting on the Nursing Home Compare

1 Medicare website (or a successor website) de-
2 scribed in section 1819(i) information on the
3 performance of skilled nursing facilities with re-
4 spect to a measure specified under paragraph
5 (1) and a measure specified under paragraph
6 (2).

7 ''(B) OPPORTUNITY TO REVIEW.—The pro-
8 cedures under subparagraph (A) shall ensure
9 that a skilled nursing facility has the oppor-
10 tunity to review and submit corrections to the
11 information that is to be made public with re-
12 spect to the facility prior to such information
13 being made public.

14 ''(C) TIMING.—Such procedures shall pro-
15 vide that the information described in subpara-
16 graph (A) is made publicly available beginning
17 not later than October 1, 2017.

18 ''(7) NON-APPLICATION OF PAPERWORK REDUC-
19 TION ACT.—Chapter 35 of title 44, United States
20 Code (commonly referred to as the 'Paperwork Re-
21 duction Act of 1995') shall not apply to this sub-
22 section.''.

23 (b) VALUE-BASED PURCHASING PROGRAM FOR
24 SKILLED NURSING FACILITIES.—Section 1888 of the So-
25 cial Security Act (42 U.S.C. 1395yy), as amended by sub-

1 section (a), is further amended by adding at the end the
2 following new subsection:
3 "(h) SKILLED NURSING FACILITY VALUE-BASED
4 PURCHASING PROGRAM.—
5 "(1) ESTABLISHMENT.—
6 "(A) IN GENERAL.—Subject to the suc-
7 ceeding provisions of this subsection, the Sec-
8 retary shall establish a skilled nursing facility
9 value-based purchasing program (in this sub-
10 section referred to as the 'SNF VBP Program')
11 under which value-based incentive payments are
12 made in a fiscal year to skilled nursing facili-
13 ties.
14 "(B) PROGRAM TO BEGIN IN FISCAL YEAR
15 2019.—The SNF VBP Program shall apply to
16 payments for services furnished on or after Oc-
17 tober 1, 2018.
18 "(2) APPLICATION OF MEASURES.—
19 "(A) IN GENERAL.—The Secretary shall
20 apply the measure specified under subsection
21 (g)(1) for purposes of the SNF VBP Program.
22 "(B) REPLACEMENT.—For purposes of the
23 SNF VBP Program, the Secretary shall apply
24 the measure specified under (g)(2) instead of

1 the measure specified under (g)(1) as soon as
2 practicable.
3 ''(3) PERFORMANCE STANDARDS.—
4 ''(A) ESTABLISHMENT.—The Secretary
5 shall establish performance standards with re-
6 spect to the measure applied under paragraph
7 (2) for a performance period for a fiscal year.
8 ''(B) HIGHER OF ACHIEVEMENT AND IM-
9 PROVEMENT.—The performance standards es-
10 tablished under subparagraph (A) shall include
11 levels of achievement and improvement. In cal-
12 culating the SNF performance score under
13 paragraph (4), the Secretary shall use the high-
14 er of either improvement or achievement.
15 ''(C) TIMING.—The Secretary shall estab-
16 lish and announce the performance standards
17 established under subparagraph (A) not later
18 than 60 days prior to the beginning of the per-
19 formance period for the fiscal year involved.
20 ''(4) SNF PERFORMANCE SCORE.—
21 ''(A) IN GENERAL.—The Secretary shall
22 develop a methodology for assessing the total
23 performance of each skilled nursing facility
24 based on performance standards established
25 under paragraph (3) with respect to the meas-

1 ure applied under paragraph (2). Using such
2 methodology, the Secretary shall provide for an
3 assessment (in this subsection referred to as the
4 'SNF performance score') for each skilled nurs-
5 ing facility for each such performance period.
6 "(B) RANKING OF SNF PERFORMANCE
7 SCORES.—The Secretary shall, for the perform-
8 ance period for each fiscal year, rank the SNF
9 performance scores determined under subpara-
10 graph (A) from low to high.
11 "(5) CALCULATION OF VALUE-BASED INCEN-
12 TIVE PAYMENTS.—
13 "(A) IN GENERAL.—With respect to a
14 skilled nursing facility, based on the ranking
15 under paragraph (4)(B) for a performance pe-
16 riod for a fiscal year, the Secretary shall in-
17 crease the adjusted Federal per diem rate de-
18 termined under subsection (e)(4)(G) otherwise
19 applicable to such skilled nursing facility (and
20 after application of paragraph (6)) for services
21 furnished by such facility during such fiscal
22 year by the value-based incentive payment
23 amount under subparagraph (B).
24 "(B) VALUE -BASED INCENTIVE PAYMENT
25 AMOUNT.—The value-based incentive payment

1 amount for services furnished by a skilled nurs-
2 ing facility in a fiscal year shall be equal to the
3 product of—
4 ''(i) the adjusted Federal per diem
5 rate determined under subsection (e)(4)(G)
6 otherwise applicable to such skilled nursing
7 facility for such services furnished by the
8 skilled nursing facility during such fiscal
9 year; and
10 ''(ii) the value-based incentive pay-
11 ment percentage specified under subpara-
12 graph (C) for the skilled nursing facility
13 for such fiscal year.
14 ''(C) VALUE-BASED INCENTIVE PAYMENT
15 PERCENTAGE.—
16 ''(i) IN GENERAL.—The Secretary
17 shall specify a value-based incentive pay-
18 ment percentage for a skilled nursing facil-
19 ity for a fiscal year which may include a
20 zero percentage.
21 ''(ii) REQUIREMENTS.—In specifying
22 the value-based incentive payment percent-
23 age for each skilled nursing facility for a
24 fiscal year under clause (i), the Secretary
25 shall ensure that—

1 "(I) such percentage is based on
2 the SNF performance score of the
3 skilled nursing facility provided under
4 paragraph (4) for the performance pe-
5 riod for such fiscal year;
6 "(II) the application of all such
7 percentages in such fiscal year results
8 in an appropriate distribution of
9 value-based incentive payments under
10 subparagraph (B) such that—
11 "(aa) skilled nursing facili-
12 ties with the highest rankings
13 under paragraph (4)(B) receive
14 the highest value-based incentive
15 payment amounts under subpara-
16 graph (B);
17 "(bb) skilled nursing facili-
18 ties with the lowest rankings
19 under paragraph (4)(B) receive
20 the lowest value-based incentive
21 payment amounts under subpara-
22 graph (B); and
23 "(cc) in the case of skilled
24 nursing facilities in the lowest 40
25 percent of the ranking under

1 paragraph (4)(B), the payment
2 rate under subparagraph (A) for
3 services furnished by such facility
4 during such fiscal year shall be
5 less than the payment rate for
6 such services for such fiscal year
7 that would otherwise apply under
8 subsection (e)(4)(G) without ap-
9 plication of this subsection; and
10 ''(III) the total amount of value-
11 based incentive payments under this
12 paragraph for all skilled nursing fa-
13 cilities in such fiscal year shall be no
14 greater than 70 percent of the total
15 amount of the reductions to payments
16 for such fiscal year under paragraph
17 (6), as estimated by the Secretary.
18 ''(6) FUNDING FOR VALUE-BASED INCENTIVE
19 PAYMENTS.—
20 ''(A) IN GENERAL.—The Secretary shall
21 reduce the adjusted Federal per diem rate de-
22 termined under subsection (e)(4)(G) otherwise
23 applicable to a skilled nursing facility for serv-
24 ices furnished by such facility during a fiscal
25 year (beginning with fiscal year 2019) by the

1 applicable percent (as defined in subparagraph
2 (B)). The Secretary shall make such reductions
3 for all skilled nursing facilities in the fiscal year
4 involved, regardless of whether or not the
5 skilled nursing facility has been determined by
6 the Secretary to have earned a value-based in-
7 centive payment under paragraph (5) for such
8 fiscal year.

9 ''(B) APPLICABLE PERCENT.—For pur-
10 poses of subparagraph (A), the term 'applicable
11 percent' means, with respect to fiscal year 2019
12 and succeeding fiscal years, 2 percent.

13 ''(7) ANNOUNCEMENT OF NET RESULT OF AD-
14 JUSTMENTS.—Under the SNF VBP Program, the
15 Secretary shall, not later than 60 days prior to the
16 fiscal year involved, inform each skilled nursing fa-
17 cility of the adjustments to payments to the skilled
18 nursing facility for services furnished by such facility
19 during the fiscal year under paragraphs (5) and (6).

20 ''(8) NO EFFECT IN SUBSEQUENT FISCAL
21 YEARS.—The value-based incentive payment under
22 paragraph (5) and the payment reduction under
23 paragraph (6) shall each apply only with respect to
24 the fiscal year involved, and the Secretary shall not
25 take into account such value-based incentive pay-

1 ment or payment reduction in making payments to
2 a skilled nursing facility under this section in a sub-
3 sequent fiscal year.
4 ''(9) PUBLIC REPORTING.—
5 ''(A) SNF SPECIFIC INFORMATION.—The
6 Secretary shall make available to the public, by
7 posting on the Nursing Home Compare Medi-
8 care website (or a successor website) described
9 in section 1819(i) in an easily understandable
10 format, information regarding the performance
11 of individual skilled nursing facilities under the
12 SNF VBP Program, with respect to a fiscal
13 year, including—
14 ''(i) the SNF performance score of the
15 skilled nursing facility for such fiscal year;
16 and
17 ''(ii) the ranking of the skilled nursing
18 facility under paragraph (4)(B) for the
19 performance period for such fiscal year.
20 ''(B) AGGREGATE INFORMATION.—The
21 Secretary shall periodically post on the Nursing
22 Home Compare Medicare website (or a suc-
23 cessor website) described in section 1819(i) ag-
24 gregate information on the SNF VBP Program,
25 including—

1 "(i) the range of SNF performance
2 scores provided under paragraph (4)(A);
3 and
4 "(ii) the number of skilled nursing fa-
5 cilities receiving value-based incentive pay-
6 ments under paragraph (5) and the range
7 and total amount of such value-based in-
8 centive payments.
9 "(10) LIMITATION ON REVIEW.—There shall be
10 no administrative or judicial review under section
11 1869, section 1878, or otherwise of the following:
12 "(A) The methodology used to determine
13 the value-based incentive payment percentage
14 and the amount of the value-based incentive
15 payment under paragraph (5).
16 "(B) The determination of the amount of
17 funding available for such value-based incentive
18 payments under paragraph (5)(C)(ii)(III) and
19 the payment reduction under paragraph (6).
20 "(C) The establishment of the performance
21 standards under paragraph (3) and the per-
22 formance period.
23 "(D) The methodology developed under
24 paragraph (4) that is used to calculate SNF

1 performance scores and the calculation of such
2 scores.
3 "(E) The ranking determinations under
4 paragraph (4)(B).
5 "(11) FUNDING FOR PROGRAM MANAGE-
6 MENT.—The Secretary shall provide for the one time
7 transfer from the Federal Hospital Insurance Trust
8 Fund established under section 1817 to the Centers
9 for Medicare & Medicaid Services Program Manage-
10 ment Account of—
11 "(A) for purposes of subsection (g)(2),
12 $2,000,000; and
13 "(B) for purposes of implementing this
14 subsection, $10,000,000.
15 Such funds shall remain available until expended.".
16 (c) MEDPAC STUDY.—Not later than June 30,
17 2021, the Medicare Payment Advisory Commission shall
18 submit to Congress a report that reviews the progress of
19 the skilled nursing facility value-based purchasing pro-
20 gram established under section 1888(h) of the Social Se-
21 curity Act, as added by subsection (b), and makes rec-
22 ommendations, as appropriate, on any improvements that
23 should be made to such program. For purposes of the pre-
24 vious sentence, the Medicare Payment Advisory Commis-
25 sion shall consider any unintended consequences with re-

1 spect to such skilled nursing facility value-based pur-
2 chasing program and any potential adjustments to the re-
3 admission measure specified under section 1888(g)(1) of
4 such Act, as added by subsection (a), for purposes of de-
5 termining the effect of the socio-economic status of a bene-
6 ficiary under the Medicare program under title XVIII of
7 the Social Security Act for the SNF performance score
8 of a skilled nursing facility provided under section
9 1888(h)(4) of such Act, as added by subsection (b).

10 **SEC. 216. IMPROVING MEDICARE POLICIES FOR CLINICAL**
11 **DIAGNOSTIC LABORATORY TESTS.**

12 (a) IN GENERAL.—Title XVIII of the Social Security
13 Act is amended by inserting after section 1834 (42 U.S.C.
14 1395m) the following new section:

15 **"SEC. 1834A. IMPROVING POLICIES FOR CLINICAL DIAG-**
16 **NOSTIC LABORATORY TESTS.**

17 "(a) REPORTING OF PRIVATE SECTOR PAYMENT
18 RATES FOR ESTABLISHMENT OF MEDICARE PAYMENT
19 RATES.—

20 "(1) IN GENERAL.—Beginning January 1,
21 2016, and every 3 years thereafter (or, annually, in
22 the case of reporting with respect to an advanced di-
23 agnostic laboratory test, as defined in subsection
24 (d)(5)), an applicable laboratory (as defined in para-
25 graph (2)) shall report to the Secretary, at a time

specified by the Secretary, applicable information (as defined in paragraph (3)) for a data collection period (as defined in paragraph (4)) for each clinical diagnostic laboratory test that the laboratory furnishes during such period for which payment is made under this part.

"(2) DEFINITION OF APPLICABLE LABORATORY.—In this section, the term 'applicable laboratory' means a laboratory that, with respect to its revenues under this title, a majority of such revenues are from this section, section 1833(h), or section 1848. The Secretary may establish a low volume or low expenditure threshold for excluding a laboratory from the definition of applicable laboratory under this paragraph, as the Secretary determines appropriate.

"(3) APPLICABLE INFORMATION DEFINED.—

"(A) IN GENERAL.—In this section, subject to subparagraph (B), the term 'applicable information' means, with respect to a laboratory test for a data collection period, the following:

"(i) The payment rate (as determined in accordance with paragraph (5)) that

was paid by each private payor for the test during the period.

"(ii) The volume of such tests for each such payor for the period.

"(B) EXCEPTION FOR CERTAIN CONTRACTUAL ARRANGEMENTS.—Such term shall not include information with respect to a laboratory test for which payment is made on a capitated basis or other similar payment basis during the data collection period.

"(4) DATA COLLECTION PERIOD DEFINED.—In this section, the term 'data collection period' means a period of time, such as a previous 12 month period, specified by the Secretary.

"(5) TREATMENT OF DISCOUNTS.—The payment rate reported by a laboratory under this subsection shall reflect all discounts, rebates, coupons, and other price concessions, including those described in section 1847A(c)(3).

"(6) ENSURING COMPLETE REPORTING.—In the case where an applicable laboratory has more than one payment rate for the same payor for the same test or more than one payment rate for different payors for the same test, the applicable laboratory shall report each such payment rate and the

volume for the test at each such rate under this subsection. Beginning with January 1, 2019, the Secretary may establish rules to aggregate reporting with respect to the situations described in the preceding sentence.

"(7) CERTIFICATION.—An officer of the laboratory shall certify the accuracy and completeness of the information reported under this subsection.

"(8) PRIVATE PAYOR DEFINED.—In this section, the term 'private payor' means the following:

"(A) A health insurance issuer and a group health plan (as such terms are defined in section 2791 of the Public Health Service Act).

"(B) A Medicare Advantage plan under part C.

"(C) A medicaid managed care organization (as defined in section 1903(m)).

"(9) CIVIL MONEY PENALTY.—

"(A) IN GENERAL.—If the Secretary determines that an applicable laboratory has failed to report or made a misrepresentation or omission in reporting information under this subsection with respect to a clinical diagnostic laboratory test, the Secretary may apply a civil money penalty in an amount of up to $10,000

per day for each failure to report or each such misrepresentation or omission.

"(B) APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

"(10) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by a laboratory under this subsection is confidential and shall not be disclosed by the Secretary or a Medicare contractor in a form that discloses the identity of a specific payor or laboratory, or prices charged or payments made to any such laboratory, except—

"(A) as the Secretary determines to be necessary to carry out this section;

"(B) to permit the Comptroller General to review the information provided;

"(C) to permit the Director of the Congressional Budget Office to review the information provided; and

1 "(D) to permit the Medicare Payment Ad-
2 visory Commission to review the information
3 provided.
4 "(11) PROTECTION FROM PUBLIC DISCLO-
5 SURE.—A payor shall not be identified on informa-
6 tion reported under this subsection. The name of an
7 applicable laboratory under this subsection shall be
8 exempt from disclosure under section 552(b)(3) of
9 title 5, United States Code.
10 "(12) REGULATIONS.—Not later than June 30,
11 2015, the Secretary shall establish through notice
12 and comment rulemaking parameters for data collec-
13 tion under this subsection.
14 "(b) PAYMENT FOR CLINICAL DIAGNOSTIC LABORA-
15 TORY TESTS.—
16 "(1) USE OF PRIVATE PAYOR RATE INFORMA-
17 TION TO DETERMINE MEDICARE PAYMENT RATES.—
18 "(A) IN GENERAL.—Subject to paragraph
19 (3) and subsections (c) and (d), in the case of
20 a clinical diagnostic laboratory test furnished on
21 or after January 1, 2017, the payment amount
22 under this section shall be equal to the weighted
23 median determined for the test under para-
24 graph (2) for the most recent data collection
25 period.

1 "(B) APPLICATION OF PAYMENT AMOUNTS
2 TO HOSPITAL LABORATORIES.—The payment
3 amounts established under this section shall
4 apply to a clinical diagnostic laboratory test
5 furnished by a hospital laboratory if such test
6 is paid for separately, and not as part of a bun-
7 dled payment under section 1833(t).
8 "(2) CALCULATION OF WEIGHTED MEDIAN.—
9 For each laboratory test with respect to which infor-
10 mation is reported under subsection (a) for a data
11 collection period, the Secretary shall calculate a
12 weighted median for the test for the period, by
13 arraying the distribution of all payment rates re-
14 ported for the period for each test weighted by vol-
15 ume for each payor and each laboratory.
16 "(3) PHASE-IN OF REDUCTIONS FROM PRIVATE
17 PAYOR RATE IMPLEMENTATION.—
18 "(A) IN GENERAL.—Payment amounts de-
19 termined under this subsection for a clinical di-
20 agnostic laboratory test for each of 2017
21 through 2022 shall not result in a reduction in
22 payments for a clinical diagnostic laboratory
23 test for the year of greater than the applicable
24 percent (as defined in subparagraph (B)) of the

amount of payment for the test for the preceding year.

"(B) APPLICABLE PERCENT DEFINED.—In this paragraph, the term 'applicable percent' means—

"(i) for each of 2017 through 2019, 10 percent; and

"(ii) for each of 2020 through 2022, 15 percent.

"(C) NO APPLICATION TO NEW TESTS.—This paragraph shall not apply to payment amounts determined under this section for either of the following.

"(i) A new test under subsection (c).

"(ii) A new advanced diagnostic test under subsection (d).

"(4) APPLICATION OF MARKET RATES.—

"(A) IN GENERAL.—Subject to paragraph (3), once established for a year following a data collection period, the payment amounts under this subsection shall continue to apply until the year following the next data collection period.

"(B) OTHER ADJUSTMENTS NOT APPLICABLE.—The payment amounts under this section shall not be subject to any adjustment (includ-

1 ing any geographic adjustment, budget neu-
2 trality adjustment, annual update, or other ad-
3 justment).

4 ''(5) SAMPLE COLLECTION FEE.—In the case of
5 a sample collected from an individual in a skilled
6 nursing facility or by a laboratory on behalf of a
7 home health agency, the nominal fee that would oth-
8 erwise apply under section 1833(h)(3)(A) shall be
9 increased by $2.

10 ''(c) PAYMENT FOR NEW TESTS THAT ARE NOT AD-
11 VANCED DIAGNOSTIC LABORATORY TESTS.—

12 ''(1) PAYMENT DURING INITIAL PERIOD.—In
13 the case of a clinical diagnostic laboratory test that
14 is assigned a new or substantially revised HCPCS
15 code on or after the date of enactment of this sec-
16 tion, and which is not an advanced diagnostic lab-
17 oratory test (as defined in subsection (d)(5)), during
18 an initial period until payment rates under sub-
19 section (b) are established for the test, payment for
20 the test shall be determined—

21 ''(A) using cross-walking (as described in
22 section 414.508(a) of title 42, Code of Federal
23 Regulations, or any successor regulation) to the
24 most appropriate existing test under the fee

1 schedule under this section during that period;
2 or
3 ''(B) if no existing test is comparable to
4 the new test, according to the gapfilling process
5 described in paragraph (2).
6 ''(2) GAPFILLING PROCESS DESCRIBED.—The
7 gapfilling process described in this paragraph shall
8 take into account the following sources of informa-
9 tion to determine gapfill amounts, if available:
10 ''(A) Charges for the test and routine dis-
11 counts to charges.
12 ''(B) Resources required to perform the
13 test.
14 ''(C) Payment amounts determined by
15 other payors.
16 ''(D) Charges, payment amounts, and re-
17 sources required for other tests that may be
18 comparable or otherwise relevant.
19 ''(E) Other criteria the Secretary deter-
20 mines appropriate.
21 ''(3) ADDITIONAL CONSIDERATION.—In deter-
22 mining the payment amount under crosswalking or
23 gapfilling processes under this subsection, the Sec-
24 retary shall consider recommendations from the
25 panel established under subsection (f)(1).

1 "(4) EXPLANATION OF PAYMENT RATES.—In
2 the case of a clinical diagnostic laboratory test for
3 which payment is made under this subsection, the
4 Secretary shall make available to the public an ex-
5 planation of the payment rate for the test, including
6 an explanation of how the criteria described in para-
7 graph (2) and paragraph (3) are applied.
8 "(d) PAYMENT FOR NEW ADVANCED DIAGNOSTIC
9 LABORATORY TESTS.—
10 "(1) PAYMENT DURING INITIAL PERIOD.—
11 "(A) IN GENERAL.—In the case of an ad-
12 vanced diagnostic laboratory test for which pay-
13 ment has not been made under the fee schedule
14 under section 1833(h) prior to the date of en-
15 actment of this section, during an initial period
16 of three quarters, the payment amount for the
17 test for such period shall be based on the actual
18 list charge for the laboratory test.
19 "(B) ACTUAL LIST CHARGE.—For pur-
20 poses of subparagraph (A), the term 'actual list
21 charge', with respect to a laboratory test fur-
22 nished during such period, means the publicly
23 available rate on the first day at which the test
24 is available for purchase by a private payor.

1 "(2) SPECIAL RULE FOR TIMING OF INITIAL
2 REPORTING.—With respect to an advanced diag-
3 nostic laboratory test described in paragraph (1)(A),
4 an applicable laboratory shall initially be required to
5 report under subsection (a) not later than the last
6 day of the second quarter of the initial period under
7 such paragraph.

8 "(3) APPLICATION OF MARKET RATES AFTER
9 INITIAL PERIOD.—Subject to paragraph (4), data re-
10 ported under paragraph (2) shall be used to estab-
11 lish the payment amount for an advanced diagnostic
12 laboratory test after the initial period under para-
13 graph (1)(A) using the methodology described in
14 subsection (b). Such payment amount shall continue
15 to apply until the year following the next data collec-
16 tion period.

17 "(4) RECOUPMENT IF ACTUAL LIST CHARGE
18 EXCEEDS MARKET RATE.—With respect to the initial
19 period described in paragraph (1)(A), if, after such
20 period, the Secretary determines that the payment
21 amount for an advanced diagnostic laboratory test
22 under paragraph (1)(A) that was applicable during
23 the period was greater than 130 percent of the pay-
24 ment amount for the test established using the
25 methodology described in subsection (b) that is ap-

1 plicable after such period, the Secretary shall recoup
2 the difference between such payment amounts for
3 tests furnished during such period.

4 ''(5) ADVANCED DIAGNOSTIC LABORATORY
5 TEST DEFINED.—In this section, the term 'advanced
6 diagnostic laboratory test' means a clinical diag-
7 nostic laboratory test covered under this part that is
8 offered and furnished only by a single laboratory
9 and not sold for use by a laboratory other than the
10 original developing laboratory (or a successor owner)
11 and meets one of the following criteria:

12 ''(A) The test is an analysis of multiple
13 biomarkers of DNA, RNA, or proteins com-
14 bined with a unique algorithm to yield a single
15 patient-specific result.

16 ''(B) The test is cleared or approved by the
17 Food and Drug Administration.

18 ''(C) The test meets other similar criteria
19 established by the Secretary.

20 ''(e) CODING.—

21 ''(1) TEMPORARY CODES FOR CERTAIN NEW
22 TESTS.—

23 ''(A) IN GENERAL.—The Secretary shall
24 adopt temporary HCPCS codes to identify new
25 advanced diagnostic laboratory tests and new

1 laboratory tests that are cleared or approved by
2 the Food and Drug Administration.
3 "(B) DURATION.—
4 "(i) IN GENERAL.—Subject to clause
5 (ii), the temporary code shall be effective
6 until a permanent HCPCS code is estab-
7 lished (but not to exceed 2 years).
8 "(ii) EXCEPTION.—The Secretary
9 may extend the temporary code or estab-
10 lish a permanent HCPCS code, as the Sec-
11 retary determines appropriate.
12 "(2) EXISTING TESTS.—Not later than January
13 1, 2016, for each existing advanced diagnostic lab-
14 oratory test and each existing clinical diagnostic lab-
15 oratory test that is cleared or approved by the Food
16 and Drug Administration for which payment is
17 made under this part as of the date of enactment of
18 this section, if such test has not already been as-
19 signed a unique HCPCS code, the Secretary shall—
20 "(A) assign a unique HCPCS code for the
21 test; and
22 "(B) publicly report the payment rate for
23 the test.
24 "(3) ESTABLISHMENT OF UNIQUE IDENTIFIER
25 FOR CERTAIN TESTS.—For purposes of tracking and

1 monitoring, if a laboratory or a manufacturer re-
2 quests a unique identifier for an advanced diagnostic
3 laboratory test or a laboratory test that is cleared or
4 approved by the Food and Drug Administration, the
5 Secretary shall utilize a means to uniquely track
6 such test through a mechanism such as a HCPCS
7 code or modifier.

8 ''(f) INPUT FROM CLINICIANS AND TECHNICAL EX-
9 PERTS.—

10 ''(1) IN GENERAL.—The Secretary shall consult
11 with an expert outside advisory panel, established by
12 the Secretary not later than July 1, 2015, composed
13 of an appropriate selection of individuals with exper-
14 tise, which may include molecular pathologists, re-
15 searchers, and individuals with expertise in labora-
16 tory science or health economics, in issues related to
17 clinical diagnostic laboratory tests, which may in-
18 clude the development, validation, performance, and
19 application of such tests, to provide—

20 ''(A) input on—

21 ''(i) the establishment of payment
22 rates under this section for new clinical di-
23 agnostic laboratory tests, including wheth-
24 er to use crosswalking or gapfilling proc-

esses to determine payment for a specific new test; and

"(ii) the factors used in determining coverage and payment processes for new clinical diagnostic laboratory tests; and

"(B) recommendations to the Secretary under this section.

"(2) COMPLIANCE WITH FACA.—The panel shall be subject to the Federal Advisory Committee Act (5 U.S.C. App.).

"(3) CONTINUATION OF ANNUAL MEETING.—The Secretary shall continue to convene the annual meeting described in section 1833(h)(8)(B)(iii) after the implementation of this section for purposes of receiving comments and recommendations (and data on which the recommendations are based) as described in such section on the establishment of payment amounts under this section.

"(g) COVERAGE.—

"(1) ISSUANCE OF COVERAGE POLICIES.—

"(A) IN GENERAL.—A medicare administrative contractor shall only issue a coverage policy with respect to a clinical diagnostic laboratory test in accordance with the process for making a local coverage determination (as de-

fined in section 1869(f)(2)(B)), including the appeals and review process for local coverage determinations under part 426 of title 42, Code of Federal Regulations (or successor regulations).

"(B) NO EFFECT ON NATIONAL COVERAGE DETERMINATION PROCESS.—This paragraph shall not apply to the national coverage determination process (as defined in section 1869(f)(1)(B)).

"(C) EFFECTIVE DATE.—This paragraph shall apply to coverage policies issued on or after January 1, 2015.

"(2) DESIGNATION OF ONE OR MORE MEDICARE ADMINISTRATIVE CONTRACTORS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—The Secretary may designate one or more (not to exceed 4) medicare administrative contractors to either establish coverage policies or establish coverage policies and process claims for payment for clinical diagnostic laboratory tests, as determined appropriate by the Secretary.

"(h) IMPLEMENTATION.—

"(1) IMPLEMENTATION.—There shall be no administrative or judicial review under section 1869,

1 section 1878, or otherwise, of the establishment of
2 payment amounts under this section.
3 ''(2) ADMINISTRATION.—Chapter 35 of title 44,
4 United States Code, shall not apply to information
5 collected under this section.
6 ''(3) FUNDING.—For purposes of implementing
7 this section, the Secretary shall provide for the
8 transfer, from the Federal Supplementary Medical
9 Insurance Trust Fund under section 1841, to the
10 Centers for Medicare & Medicaid Services Program
11 Management Account, for each of fiscal years 2014
12 through 2018, $4,000,000, and for each of fiscal
13 years 2019 through 2023, $3,000,000. Amounts
14 transferred under the preceding sentence shall re-
15 main available until expended.''.
16 (b) CONFORMING AMENDMENTS.—
17 (1) Section 1833(a) of the Social Security Act
18 (42 U.S.C. 1395l(a)) is amended—
19 (A) in paragraph (1)(D)—
20 (i) by striking ''(i) on the basis'' and
21 inserting ''(i)(I) on the basis'';
22 (ii) in subclause (I), as added by
23 clause (i), by striking ''subsection (h)(1)''
24 and inserting ''subsection (h)(1) (for tests
25 furnished before January 1, 2017)'';

1 (iii) by striking ''or (ii)'' and inserting
2 ''or (II) under section 1834A (for tests
3 furnished on or after January 1, 2017),
4 the amount paid shall be equal to 80 per-
5 cent (or 100 percent, in the case of such
6 tests for which payment is made on an as-
7 signment-related basis) of the lesser of the
8 amount determined under such section or
9 the amount of the charges billed for the
10 tests, or (ii)''; and
11 (iv) in clause (ii), by striking ''on the
12 basis'' and inserting ''for tests furnished
13 before January 1, 2017, on the basis'';
14 (B) in paragraph (2)(D)—
15 (i) by striking ''(i) on the basis'' and
16 inserting ''(i)(I) on the basis'';
17 (ii) in subclause (I), as added by
18 clause (i), by striking ''subsection (h)(1)''
19 and inserting ''subsection (h)(1) (for tests
20 furnished before January 1, 2017)'';
21 (iii) by striking ''or (ii)'' and inserting
22 ''or (II) under section 1834A (for tests
23 furnished on or after January 1, 2017),
24 the amount paid shall be equal to 80 per-
25 cent (or 100 percent, in the case of such

tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866) of the lesser of the amount determined under such section or the amount of the charges billed for the tests, or (ii)''; and

(iv) in clause (ii), by striking ''on the basis'' and inserting ''for tests furnished before January 1, 2017, on the basis'';

(C) in subsection (b)(3)(B), by striking ''on the basis'' and inserting ''for tests furnished before January 1, 2017, on the basis'';

(D) in subsection (h)(2)(A)(i), by striking ''and subject to'' and inserting ''and, for tests furnished before the date of enactment of section 1834A, subject to'';

(E) in subsection (h)(3), in the matter preceding subparagraph (A), by striking ''fee schedules'' and inserting ''fee schedules (for tests furnished before January 1, 2017) or under section 1834A (for tests furnished on or after January 1, 2017), subject to subsection (b)(5) of such section'';

(F) in subsection (h)(6), by striking ''In the case'' and inserting ''For tests furnished before January 1, 2017, in the case''; and

(G) in subsection (h)(7), in the first sentence—

(i) by striking ''and (4)'' and inserting ''and (4) and section 1834A''; and

(ii) by striking ''under this subsection'' and inserting ''under this part''.

(2) Section 1869(f)(2) of the Social Security Act (42 U.S.C. 1395ff(f)(2)) is amended by adding at the end the following new subparagraph:

''(C) LOCAL COVERAGE DETERMINATIONS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—For provisions relating to local coverage determinations for clinical diagnostic laboratory tests, see section 1834A(g).''.

(c) GAO STUDY AND REPORT; MONITORING OF MEDICARE EXPENDITURES AND IMPLEMENTATION OF NEW PAYMENT SYSTEM FOR LABORATORY TESTS.—

(1) GAO STUDY AND REPORT ON IMPLEMENTATION OF NEW PAYMENT RATES FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—

(A) STUDY.—The Comptroller General of the United States (in this subsection referred to

as the "Comptroller General") shall conduct a study on the implementation of section 1834A of the Social Security Act, as added by subsection (a). The study shall include an analysis of—

(i) payment rates paid by private payors for laboratory tests furnished in various settings, including—

(I) how such payment rates compare across settings;

(II) the trend in payment rates over time; and

(III) trends by private payors to move to alternative payment methodologies for laboratory tests;

(ii) the conversion to the new payment rate for laboratory tests under such section;

(iii) the impact of such implementation on beneficiary access under title XVIII of the Social Security Act;

(iv) the impact of the new payment system on laboratories that furnish a low volume of services and laboratories that specialize in a small number of tests;

1 (v) the number of new Healthcare
2 Common Procedure Coding System
3 (HCPCS) codes issued for laboratory tests;
4 (vi) the spending trend for laboratory
5 tests under such title;
6 (vii) whether the information reported
7 by laboratories and the new payment rates
8 for laboratory tests under such section ac-
9 curately reflect market prices;
10 (viii) the initial list price for new lab-
11 oratory tests and the subsequent reported
12 rates for such tests under such section;
13 (ix) changes in the number of ad-
14 vanced diagnostic laboratory tests and lab-
15 oratory tests cleared or approved by the
16 Food and Drug Administration for which
17 payment is made under such section; and
18 (x) healthcare economic information
19 on downstream cost impacts for such tests
20 and decision making based on accepted
21 methodologies.
22 (B) REPORT.—Not later than October 1,
23 2018, the Comptroller General shall submit to
24 the Committee on Ways and Means and the
25 Committee on Energy and Commerce of the

House of Representatives and the Committee on Finance of the Senate a report on the study under subparagraph (A), including recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(2) MONITORING OF MEDICARE EXPENDITURES AND IMPLEMENTATION OF NEW PAYMENT SYSTEM FOR LABORATORY TESTS.—The Inspector General of the Department of Health and Human Services shall—

(A) publicly release an annual analysis of the top 25 laboratory tests by expenditures under title XVIII of the Social Security Act; and

(B) conduct analyses the Inspector General determines appropriate with respect to the implementation and effect of the new payment system for laboratory tests under section 1834A of the Social Security Act, as added by subsection (a).

SEC. 217. REVISIONS UNDER THE MEDICARE ESRD PROSPECTIVE PAYMENT SYSTEM.

(a) DELAY OF IMPLEMENTATION OF ORAL-ONLY POLICY.—Section 632(b)(1) of the American Taxpayer Relief Act of 2012 (42 U.S.C. 1395rr note) is amended—

(1) by striking ''2016'' and inserting ''2024''; and

(2) by adding at the end the following new sentence: ''Notwithstanding section 1881(b)(14)(A)(ii) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(A)(ii)), implementation of the policy described in the previous sentence shall be based on data from the most recent year available.''.

(b) MITIGATION OF THE APPLICATION OF ADJUSTMENT TO ESRD BUNDLED PAYMENT RATE TO ACCOUNT FOR CHANGES IN THE UTILIZATION OF CERTAIN DRUGS AND BIOLOGICALS.—

(1) IN GENERAL.—Section 1881(b)(14)(I) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(I)) is amended by inserting ''and before January 1, 2016,'' after ''January 1, 2014,''.

(2) MARKET BASKET.—Section 1881(b)(14)(F)(i)(I) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(F)(i)(I)) is amended by adding at the end the following new sentence: ''In order to accomplish the purposes of subparagraph (I) with

respect to 2016, 2017, and 2018, after determining the increase factor described in the preceding sentence for each of 2016, 2017, and 2018, the Secretary shall reduce such increase factor by 1.25 percentage points for each of 2016 and 2017 and by 1 percentage point for 2018.''.

(c) DRUG DESIGNATIONS.—As part of the promulgation of annual rule for the Medicare end stage renal disease prospective payment system under section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) for calendar year 2016, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a process for—

(1) determining when a product is no longer an oral-only drug; and

(2) including new injectable and intravenous products into the bundled payment under such system.

(d) QUALITY MEASURES RELATED TO CONDITIONS TREATED BY ORAL-ONLY DRUGS UNDER THE ESRD QUALITY INCENTIVE PROGRAM.—Section 1881(h)(2) of the Social Security Act (42 U.S.C. 1395rr(h)(2)) is amended—

(1) in subparagraph (A)—

(A) in clause (ii), by striking ''and'' at the end;

(B) by redesignating clause (iii) as clause (iv); and

(C) by inserting after clause (ii) the following new clause:

''(iii) for 2016 and subsequent years, measures described in subparagraph (E)(i); and'';

(2) in subparagraph (B)(i), by striking ''(A)(iii)'' and inserting ''(A)(iv)''; and

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

''(E) MEASURES SPECIFIC TO THE CONDITIONS TREATED WITH ORAL-ONLY DRUGS.—

''(i) IN GENERAL.—The measures described in this subparagraph are measures specified by the Secretary that are specific to the conditions treated with oral-only drugs. To the extent feasible, such measures shall be outcomes-based measures.

''(ii) CONSULTATION.—In specifying the measures under clause (i), the Secretary shall consult with interested stakeholders.

1 "(iii) USE OF ENDORSED MEAS-
2 URES.—
3 "(I) IN GENERAL.—Subject to
4 subclause (I), any measures specified
5 under clause (i) must have been en-
6 dorsed by the entity with a contract
7 under section 1890(a).
8 "(II) EXCEPTION.—If the entity
9 with a contract under section 1890(a)
10 has not endorsed a measure for a
11 specified area or topic related to
12 measures described in clause (i) that
13 the Secretary determines appropriate,
14 the Secretary may specify a measure
15 that is endorsed or adopted by a con-
16 sensus organization recognized by the
17 Secretary that has expertise in clinical
18 guidelines for kidney disease.".
19 (e) AUDITS OF COST REPORTS OF ESRD PROVIDERS
20 AS RECOMMENDED BY MEDPAC.—
21 (1) IN GENERAL.—The Secretary of Health and
22 Human Services shall conduct audits of Medicare
23 cost reports beginning during 2012 for a representa-
24 tive sample of providers of services and renal dialysis
25 facilities furnishing renal dialysis services.

1 (2) FUNDING.—For purposes of carrying out
2 paragraph (1), the Secretary of Health and Human
3 Services shall provide for the transfer from the Fed-
4 eral Supplementary Medical Insurance Trust Fund
5 established under section 1841 of the Social Security
6 Act (42 U.S.C. 1395t) to the Centers for Medicare
7 & Medicaid Services Program Management Account
8 of $18,000,000 for fiscal year 2014. Amounts trans-
9 ferred under this paragraph for a fiscal year shall be
10 available until expended.

11 **SEC. 218. QUALITY INCENTIVES FOR COMPUTED TOMOG-**
12 **RAPHY DIAGNOSTIC IMAGING AND PRO-**
13 **MOTING EVIDENCE-BASED CARE.**

14 (a) QUALITY INCENTIVES TO PROMOTE PATIENT
15 SAFETY AND PUBLIC HEALTH IN COMPUTED TOMOG-
16 RAPHY DIAGNOSTIC IMAGING.—

17 (1) IN GENERAL.—Section 1834 of the Social
18 Security Act (42 U.S.C. 1395m) is amended by add-
19 ing at the end the following new subsection:

20 ''(p) QUALITY INCENTIVES TO PROMOTE PATIENT
21 SAFETY AND PUBLIC HEALTH IN COMPUTED TOMOG-
22 RAPHY.—

23 ''(1) QUALITY INCENTIVES.—In the case of an
24 applicable computed tomography service (as defined
25 in paragraph (2)) for which payment is made under

1 an applicable payment system (as defined in para-
2 graph (3)) and that is furnished on or after January
3 1, 2016, using equipment that is not consistent with
4 the CT equipment standard (described in paragraph
5 (4)), the payment amount for such service shall be
6 reduced by the applicable percentage (as defined in
7 paragraph (5)).

8 ''(2) APPLICABLE COMPUTED TOMOGRAPHY
9 SERVICES DEFINED.—In this subsection, the term
10 'applicable computed tomography service' means a
11 service billed using diagnostic radiological imaging
12 codes for computed tomography (identified as of
13 January 1, 2014, by HCPCS codes 70450–70498,
14 71250–71275, 72125–72133, 72191–72194, 73200–
15 73206, 73700–73706, 74150–74178, 74261–74263,
16 and 75571–75574 (and any succeeding codes).

17 ''(3) APPLICABLE PAYMENT SYSTEM DE-
18 FINED.—In this subsection, the term 'applicable
19 payment system' means the following:

20 ''(A) The technical component and the
21 technical component of the global fee under the
22 fee schedule established under section 1848(b).

23 ''(B) The prospective payment system for
24 hospital outpatient department services under
25 section 1833(t).

1 "(4) CONSISTENCY WITH CT EQUIPMENT
2 STANDARD.—In this subsection, the term 'not con-
3 sistent with the CT equipment standard' means,
4 with respect to an applicable computed tomography
5 service, that the service was furnished using equip-
6 ment that does not meet each of the attributes of
7 the National Electrical Manufacturers Association
8 (NEMA) Standard XR–29–2013, entitled 'Standard
9 Attributes on CT Equipment Related to Dose Opti-
10 mization and Management'. Through rulemaking,
11 the Secretary may apply successor standards.
12 "(5) APPLICABLE PERCENTAGE DEFINED.—In
13 this subsection, the term 'applicable percentage'
14 means—
15 "(A) for 2016, 5 percent; and
16 "(B) for 2017 and subsequent years, 15
17 percent.
18 "(6) IMPLEMENTATION.—
19 "(A) INFORMATION.—The Secretary shall
20 require that information be provided and at-
21 tested to by a supplier and a hospital outpatient
22 department that indicates whether an applicable
23 computed tomography service was furnished
24 that was not consistent with the CT equipment
25 standard (described in paragraph (4)). Such in-

1 formation may be included on a claim and may
2 be a modifier. Such information shall be
3 verified, as appropriate, as part of the periodic
4 accreditation of suppliers under section 1834(e)
5 and hospitals under section 1865(a).
6 ''(B) ADMINISTRATION.—Chapter 35 of
7 title 44, United States Code, shall not apply to
8 information described in subparagraph (A).''.
9 (2) CONFORMING AMENDMENTS.—
10 (A) PROSPECTIVE PAYMENT SYSTEM FOR
11 HOSPITAL OUTPATIENT DEPARTMENT SERV-
12 ICES.—Section 1833(t) of the Social Security
13 Act (42 1395l(t)) is amended by adding at the
14 end the following new paragraph:
15 ''(20) NOT BUDGET NEUTRAL APPLICATION OF
16 REDUCED EXPENDITURES RESULTING FROM QUAL-
17 ITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—
18 The Secretary shall not take into account the re-
19 duced expenditures that result from the application
20 of section 1834(p) in making any budget neutrality
21 adjustments this subsection.''.
22 (B) PHYSICIAN FEE SCHEDULE.—Section
23 1848(c)(2)(B)(v) of the Social Security Act (42
24 U.S.C. 1395w–4(c)(2)(B)(v)) is amended by
25 adding at the end the following new subclause:

1 "(VIII) REDUCED EXPENDI-
2 TURES ATTRIBUTABLE TO APPLICA-
3 TION OF QUALITY INCENTIVES FOR
4 COMPUTED TOMOGRAPHY.—Effective
5 for fee schedules established beginning
6 with 2016, reduced expenditures at-
7 tributable to the application of the
8 quality incentives for computed to-
9 mography under section 1834(p)".
10 (b) PROMOTING EVIDENCE-BASED CARE.—
11 (1) IN GENERAL.—Section 1834 of the Social
12 Security Act (42 U.S.C. 1395m), as amended by
13 subsection (a), is amended by adding at the end the
14 following new subsection:
15 "(q) RECOGNIZING APPROPRIATE USE CRITERIA FOR
16 CERTAIN IMAGING SERVICES.—
17 "(1) PROGRAM ESTABLISHED.—
18 "(A) IN GENERAL.—The Secretary shall
19 establish a program to promote the use of ap-
20 propriate use criteria (as defined in subpara-
21 graph (B)) for applicable imaging services (as
22 defined in subparagraph (C)) furnished in an
23 applicable setting (as defined in subparagraph
24 (D)) by ordering professionals and furnishing

1 professionals (as defined in subparagraphs (E)
2 and (F), respectively).
3 "(B) APPROPRIATE USE CRITERIA DE-
4 FINED.—In this subsection, the term 'appro-
5 priate use criteria' means criteria, only devel-
6 oped or endorsed by national professional med-
7 ical specialty societies or other provider-led enti-
8 ties, to assist ordering professionals and fur-
9 nishing professionals in making the most appro-
10 priate treatment decision for a specific clinical
11 condition for an individual. To the extent fea-
12 sible, such criteria shall be evidence-based.
13 "(C) APPLICABLE IMAGING SERVICE DE-
14 FINED.—In this subsection, the term 'applicable
15 imaging service' means an advanced diagnostic
16 imaging service (as defined in subsection
17 (e)(1)(B)) for which the Secretary determines—
18 "(i) one or more applicable appro-
19 priate use criteria specified under para-
20 graph (2) apply;
21 "(ii) there are one or more qualified
22 clinical decision support mechanisms listed
23 under paragraph (3)(C); and
24 "(iii) one or more of such mechanisms
25 is available free of charge.

1 "(D) APPLICABLE SETTING DEFINED.—In
2 this subsection, the term 'applicable setting'
3 means a physician's office, a hospital outpatient
4 department (including an emergency depart-
5 ment), an ambulatory surgical center, and any
6 other provider-led outpatient setting determined
7 appropriate by the Secretary.
8 "(E) ORDERING PROFESSIONAL DE-
9 FINED.—In this subsection, the term 'ordering
10 professional' means a physician (as defined in
11 section 1861(r)) or a practitioner described in
12 section 1842(b)(18)(C) who orders an applica-
13 ble imaging service.
14 "(F) FURNISHING PROFESSIONAL DE-
15 FINED.—In this subsection, the term 'fur-
16 nishing professional' means a physician (as de-
17 fined in section 1861(r)) or a practitioner de-
18 scribed in section 1842(b)(18)(C) who furnishes
19 an applicable imaging service.
20 "(2) ESTABLISHMENT OF APPLICABLE APPRO-
21 PRIATE USE CRITERIA.—
22 "(A) IN GENERAL.—Not later than No-
23 vember 15, 2015, the Secretary shall through
24 rulemaking, and in consultation with physi-
25 cians, practitioners, and other stakeholders,

1 specify applicable appropriate use criteria for
2 applicable imaging services only from among
3 appropriate use criteria developed or endorsed
4 by national professional medical specialty soci-
5 eties or other provider-led entities.

6 ''(B) CONSIDERATIONS.—In specifying ap-
7 plicable appropriate use criteria under subpara-
8 graph (A), the Secretary shall take into account
9 whether the criteria—

10 ''(i) have stakeholder consensus;

11 ''(ii) are scientifically valid and evi-
12 dence based; and

13 ''(iii) are based on studies that are
14 published and reviewable by stakeholders.

15 ''(C) REVISIONS.—The Secretary shall re-
16 view, on an annual basis, the specified applica-
17 ble appropriate use criteria to determine if
18 there is a need to update or revise (as appro-
19 priate) such specification of applicable appro-
20 priate use criteria and make such updates or
21 revisions through rulemaking.

22 ''(D) TREATMENT OF MULTIPLE APPLICA-
23 BLE APPROPRIATE USE CRITERIA.—In the case
24 where the Secretary determines that more than
25 one appropriate use criterion applies with re-

spect to an applicable imaging service, the Secretary shall apply one or more applicable appropriate use criteria under this paragraph for the service.

"(3) MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(A) IDENTIFICATION OF MECHANISMS TO CONSULT WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(i) IN GENERAL.—The Secretary shall specify qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

"(ii) CONSULTATION.—The Secretary shall consult with physicians, practitioners, health care technology experts, and other stakeholders in specifying mechanisms under this paragraph.

"(iii) INCLUSION OF CERTAIN MECHANISMS.—Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

1 "(I) Use of clinical decision sup-
2 port modules in certified EHR tech-
3 nology (as defined in section
4 1848(o)(4)).
5 "(II) Use of private sector clin-
6 ical decision support mechanisms that
7 are independent from certified EHR
8 technology, which may include use of
9 clinical decision support mechanisms
10 available from medical specialty orga-
11 nizations.
12 "(III) Use of a clinical decision
13 support mechanism established by the
14 Secretary.
15 "(B) QUALIFIED CLINICAL DECISION SUP-
16 PORT MECHANISMS.—
17 "(i) IN GENERAL.—For purposes of
18 this subsection, a qualified clinical decision
19 support mechanism is a mechanism that
20 the Secretary determines meets the re-
21 quirements described in clause (ii).
22 "(ii) REQUIREMENTS.—The require-
23 ments described in this clause are the fol-
24 lowing:

1 ''(I) The mechanism makes avail-
2 able to the ordering professional appli-
3 cable appropriate use criteria specified
4 under paragraph (2) and the sup-
5 porting documentation for the applica-
6 ble imaging service ordered.
7 ''(II) In the case where there is
8 more than one applicable appropriate
9 use criterion specified under such
10 paragraph for an applicable imaging
11 service, the mechanism indicates the
12 criteria that it uses for the service.
13 ''(III) The mechanism determines
14 the extent to which an applicable im-
15 aging service ordered is consistent
16 with the applicable appropriate use
17 criteria so specified.
18 ''(IV) The mechanism generates
19 and provides to the ordering profes-
20 sional a certification or documentation
21 that documents that the qualified clin-
22 ical decision support mechanism was
23 consulted by the ordering professional.
24 ''(V) The mechanism is updated
25 on a timely basis to reflect revisions

to the specification of applicable appropriate use criteria under such paragraph.

"(VI) The mechanism meets privacy and security standards under applicable provisions of law.

"(VII) The mechanism performs such other functions as specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering professional.

"(C) LIST OF MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

"(i) INITIAL LIST.—Not later than April 1, 2016, the Secretary shall publish a list of mechanisms specified under this paragraph.

"(ii) PERIODIC UPDATING OF LIST.—The Secretary shall identify on an annual basis the list of qualified clinical decision support mechanisms specified under this paragraph.

"(4) CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

1 "(A) CONSULTATION BY ORDERING PRO-
2 FESSIONAL.—Beginning with January 1, 2017,
3 subject to subparagraph (C), with respect to an
4 applicable imaging service ordered by an order-
5 ing professional that would be furnished in an
6 applicable setting and paid for under an appli-
7 cable payment system (as defined in subpara-
8 graph (D)), an ordering professional shall—
9 "(i) consult with a qualified decision
10 support mechanism listed under paragraph
11 (3)(C); and
12 "(ii) provide to the furnishing profes-
13 sional the information described in clauses
14 (i) through (iii) of subparagraph (B).
15 "(B) REPORTING BY FURNISHING PROFES-
16 SIONAL.—Beginning with January 1, 2017,
17 subject to subparagraph (C), with respect to an
18 applicable imaging service furnished in an ap-
19 plicable setting and paid for under an applica-
20 ble payment system (as defined in subpara-
21 graph (D)), payment for such service may only
22 be made if the claim for the service includes the
23 following:
24 "(i) Information about which qualified
25 clinical decision support mechanism was

1 consulted by the ordering professional for
2 the service.
3 ''(ii) Information regarding—
4 ''(I) whether the service ordered
5 would adhere to the applicable appro-
6 priate use criteria specified under
7 paragraph (2);
8 ''(II) whether the service ordered
9 would not adhere to such criteria; or
10 ''(III) whether such criteria was
11 not applicable to the service ordered.
12 ''(iii) The national provider identifier
13 of the ordering professional (if different
14 from the furnishing professional).
15 ''(C) EXCEPTIONS.—The provisions of sub-
16 paragraphs (A) and (B) and paragraph (6)(A)
17 shall not apply to the following:
18 ''(i) EMERGENCY SERVICES.—An ap-
19 plicable imaging service ordered for an in-
20 dividual with an emergency medical condi-
21 tion (as defined in section 1867(e)(1)).
22 ''(ii) INPATIENT SERVICES.—An appli-
23 cable imaging service ordered for an inpa-
24 tient and for which payment is made under
25 part A.

1 "(iii) SIGNIFICANT HARDSHIP.—An
2 applicable imaging service ordered by an
3 ordering professional who the Secretary
4 may, on a case-by-case basis, exempt from
5 the application of such provisions if the
6 Secretary determines, subject to annual re-
7 newal, that consultation with applicable ap-
8 propriate use criteria would result in a sig-
9 nificant hardship, such as in the case of a
10 professional who practices in a rural area
11 without sufficient Internet access.
12 "(D) APPLICABLE PAYMENT SYSTEM DE-
13 FINED.—In this subsection, the term 'applicable
14 payment system' means the following:
15 "(i) The physician fee schedule estab-
16 lished under section 1848(b).
17 "(ii) The prospective payment system
18 for hospital outpatient department services
19 under section 1833(t).
20 "(iii) The ambulatory surgical center
21 payment systems under section 1833(i).
22 "(5) IDENTIFICATION OF OUTLIER ORDERING
23 PROFESSIONALS.—
24 "(A) IN GENERAL.—With respect to appli-
25 cable imaging services furnished beginning with

2017, the Secretary shall determine, on an annual basis, no more than five percent of the total number of ordering professionals who are outlier ordering professionals.

"(B) OUTLIER ORDERING PROFESSIONALS.—The determination of an outlier ordering professional shall—

"(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based on comparison to other ordering professionals; and

"(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

"(C) USE OF TWO YEARS OF DATA.—The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

"(D) PROCESS.—The Secretary shall establish a process for determining when an outlier ordering professional is no longer an outlier ordering professional.

"(E) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with

1 physicians, practitioners and other stakeholders
2 in developing methods to identify outlier order-
3 ing professionals under this paragraph.
4 "(6) PRIOR AUTHORIZATION FOR ORDERING
5 PROFESSIONALS WHO ARE OUTLIERS.—
6 "(A) IN GENERAL.—Beginning January 1,
7 2020, subject to paragraph (4)(C), with respect
8 to services furnished during a year, the Sec-
9 retary shall, for a period determined appro-
10 priate by the Secretary, apply prior authoriza-
11 tion for applicable imaging services that are or-
12 dered by an outlier ordering professional identi-
13 fied under paragraph (5).
14 "(B) APPROPRIATE USE CRITERIA IN
15 PRIOR AUTHORIZATION.—In applying prior au-
16 thorization under subparagraph (A), the Sec-
17 retary shall utilize only the applicable appro-
18 priate use criteria specified under this sub-
19 section.
20 "(C) FUNDING.—For purposes of carrying
21 out this paragraph, the Secretary shall provide
22 for the transfer, from the Federal Supple-
23 mentary Medical Insurance Trust Fund under
24 section 1841, of $5,000,000 to the Centers for
25 Medicare & Medicaid Services Program Man-

1 agement Account for each of fiscal years 2019
2 through 2021. Amounts transferred under the
3 preceding sentence shall remain available until
4 expended.

5 ''(7) CONSTRUCTION.—Nothing in this sub-
6 section shall be construed as granting the Secretary
7 the authority to develop or initiate the development
8 of clinical practice guidelines or appropriate use cri-
9 teria.''.

10 (2) CONFORMING AMENDMENT.—Section
11 1833(t)(16) of the Social Security Act (42 U.S.C.
12 1395l(t)(16)) is amended by adding at the end the
13 following new subparagraph:

14 ''(E) APPLICATION OF APPROPRIATE USE
15 CRITERIA FOR CERTAIN IMAGING SERVICES.—
16 For provisions relating to the application of ap-
17 propriate use criteria for certain imaging serv-
18 ices, see section 1834(q).''.

19 (3) REPORT ON EXPERIENCE OF IMAGING AP-
20 PROPRIATE USE CRITERIA PROGRAM.—Not later
21 than 18 months after the date of the enactment of
22 this Act, the Comptroller General of the United
23 States shall submit to Congress a report that in-
24 cludes a description of the extent to which appro-
25 priate use criteria could be used for other services

under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), such as radiation therapy and clinical diagnostic laboratory services.

SEC. 219. USING FUNDING FROM TRANSITIONAL FUND FOR SUSTAINABLE GROWTH RATE (SGR) REFORM.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''$2,300,000,000'' and inserting ''$0''.

SEC. 220. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

(1) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

''(M) AUTHORITY TO COLLECT AND USE INFORMATION ON PHYSICIANS' SERVICES IN THE DETERMINATION OF RELATIVE VALUES.—

''(i) COLLECTION OF INFORMATION.—Notwithstanding any other provision of law, the Secretary may collect or obtain information on the resources directly or indirectly related to furnishing services for

which payment is made under the fee schedule established under subsection (b). Such information may be collected or obtained from any eligible professional or any other source.

"(ii) USE OF INFORMATION.—Notwithstanding any other provision of law, subject to clause (v), the Secretary may (as the Secretary determines appropriate) use information collected or obtained pursuant to clause (i) in the determination of relative values for services under this section.

"(iii) TYPES OF INFORMATION.—The types of information described in clauses (i) and (ii) may, at the Secretary's discretion, include any or all of the following:

"(I) Time involved in furnishing services.

"(II) Amounts and types of practice expense inputs involved with furnishing services.

"(III) Prices (net of any discounts) for practice expense inputs,

which may include paid invoice prices or other documentation or records.

"(IV) Overhead and accounting information for practices of physicians and other suppliers.

"(V) Any other element that would improve the valuation of services under this section.

"(iv) INFORMATION COLLECTION MECHANISMS.—Information may be collected or obtained pursuant to this subparagraph from any or all of the following:

"(I) Surveys of physicians, other suppliers, providers of services, manufacturers, and vendors.

"(II) Surgical logs, billing systems, or other practice or facility records.

"(III) Electronic health records.

"(IV) Any other mechanism determined appropriate by the Secretary.

"(v) TRANSPARENCY OF USE OF INFORMATION.—

1 "(I) IN GENERAL.—Subject to
2 subclauses (II) and (III), if the Sec-
3 retary uses information collected or
4 obtained under this subparagraph in
5 the determination of relative values
6 under this subsection, the Secretary
7 shall disclose the information source
8 and discuss the use of such informa-
9 tion in such determination of relative
10 values through notice and comment
11 rulemaking.
12 "(II) THRESHOLDS FOR USE.—
13 The Secretary may establish thresh-
14 olds in order to use such information,
15 including the exclusion of information
16 collected or obtained from eligible pro-
17 fessionals who use very high resources
18 (as determined by the Secretary) in
19 furnishing a service.
20 "(III) DISCLOSURE OF INFORMA-
21 TION.—The Secretary shall make ag-
22 gregate information available under
23 this subparagraph but shall not dis-
24 close information in a form or manner
25 that identifies an eligible professional

1 or a group practice, or information
2 collected or obtained pursuant to a
3 nondisclosure agreement.
4 ''(vi) INCENTIVE TO PARTICIPATE.—
5 The Secretary may provide for such pay-
6 ments under this part to an eligible profes-
7 sional that submits such solicited informa-
8 tion under this subparagraph as the Sec-
9 retary determines appropriate in order to
10 compensate such eligible professional for
11 such submission. Such payments shall be
12 provided in a form and manner specified
13 by the Secretary.
14 ''(vii) ADMINISTRATION.—Chapter 35
15 of title 44, United States Code, shall not
16 apply to information collected or obtained
17 under this subparagraph.
18 ''(viii) DEFINITION OF ELIGIBLE PRO-
19 FESSIONAL.—In this subparagraph, the
20 term 'eligible professional' has the meaning
21 given such term in subsection (k)(3)(B).
22 ''(ix) FUNDING.—For purposes of car-
23 rying out this subparagraph, in addition to
24 funds otherwise appropriated, the Sec-
25 retary shall provide for the transfer, from

the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $2,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year beginning with fiscal year 2014. Amounts transferred under the preceding sentence for a fiscal year shall be available until expended.''.

(2) LIMITATION ON REVIEW.—Section 1848(i)(1) of the Social Security Act (42 U.S.C. 1395w–4(i)(1)) is amended—

(A) in subparagraph (D), by striking ''and'' at the end;

(B) in subparagraph (E), by striking the period at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(F) the collection and use of information in the determination of relative values under subsection (c)(2)(M).''.

(b) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is

amended by adding at the end the following new subparagraph:

"(N) AUTHORITY FOR ALTERNATIVE APPROACHES TO ESTABLISHING PRACTICE EXPENSE RELATIVE VALUES.—The Secretary may establish or adjust practice expense relative values under this subsection using cost, charge, or other data from suppliers or providers of services, including information collected or obtained under subparagraph (M).".

(c) REVISED AND EXPANDED IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—Section 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(K)(ii)) is amended to read as follows:

"(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued codes pursuant to clause (i)(I), the Secretary shall examine codes (and families of codes as appropriate) based on any or all of the following criteria:

"(I) Codes that have experienced the fastest growth.

1 ''(II) Codes that have experi-
2 enced substantial changes in practice
3 expenses.
4 ''(III) Codes that describe new
5 technologies or services within an ap-
6 propriate time period (such as 3
7 years) after the relative values are ini-
8 tially established for such codes.
9 ''(IV) Codes which are multiple
10 codes that are frequently billed in con-
11 junction with furnishing a single serv-
12 ice.
13 ''(V) Codes with low relative val-
14 ues, particularly those that are often
15 billed multiple times for a single treat-
16 ment.
17 ''(VI) Codes that have not been
18 subject to review since implementation
19 of the fee schedule.
20 ''(VII) Codes that account for
21 the majority of spending under the
22 physician fee schedule.
23 ''(VIII) Codes for services that
24 have experienced a substantial change

in the hospital length of stay or procedure time.

''(IX) Codes for which there may be a change in the typical site of service since the code was last valued.

''(X) Codes for which there is a significant difference in payment for the same service between different sites of service.

''(XI) Codes for which there may be anomalies in relative values within a family of codes.

''(XII) Codes for services where there may be efficiencies when a service is furnished at the same time as other services.

''(XIII) Codes with high intra-service work per unit of time.

''(XIV) Codes with high practice expense relative value units.

''(XV) Codes with high cost supplies.

''(XVI) Codes as determined appropriate by the Secretary.''.

1 (d) TARGET FOR RELATIVE VALUE ADJUSTMENTS
2 FOR MISVALUED SERVICES.—
3 (1) IN GENERAL.—Section 1848(c)(2) of the
4 Social Security Act (42 U.S.C. 1395w–4(c)(2)), as
5 amended by subsections (a) and (b), is amended by
6 adding at the end the following new subparagraph:
7 "(O) TARGET FOR RELATIVE VALUE AD-
8 JUSTMENTS FOR MISVALUED SERVICES.—With
9 respect to fee schedules established for each of
10 2017 through 2020, the following shall apply:
11 "(i) DETERMINATION OF NET REDUC-
12 TION IN EXPENDITURES.—For each year,
13 the Secretary shall determine the esti-
14 mated net reduction in expenditures under
15 the fee schedule under this section with re-
16 spect to the year as a result of adjust-
17 ments to the relative values established
18 under this paragraph for misvalued codes.
19 "(ii) BUDGET NEUTRAL REDISTRIBU-
20 TION OF FUNDS IF TARGET MET AND
21 COUNTING OVERAGES TOWARDS THE TAR-
22 GET FOR THE SUCCEEDING YEAR.—If the
23 estimated net reduction in expenditures de-
24 termined under clause (i) for the year is

1 equal to or greater than the target for the
2 year—
3 "(I) reduced expenditures attrib-
4 utable to such adjustments shall be
5 redistributed for the year in a budget
6 neutral manner in accordance with
7 subparagraph (B)(ii)(II); and
8 "(II) the amount by which such
9 reduced expenditures exceeds the tar-
10 get for the year shall be treated as a
11 reduction in expenditures described in
12 clause (i) for the succeeding year, for
13 purposes of determining whether the
14 target has or has not been met under
15 this subparagraph with respect to that
16 year.
17 "(iii) EXEMPTION FROM BUDGET
18 NEUTRALITY IF TARGET NOT MET.—If the
19 estimated net reduction in expenditures de-
20 termined under clause (i) for the year is
21 less than the target for the year, reduced
22 expenditures in an amount equal to the
23 target recapture amount shall not be taken
24 into account in applying subparagraph

(B)(ii)(II) with respect to fee schedules beginning with 2017.

"(iv) TARGET RECAPTURE AMOUNT.—For purposes of clause (iii), the target recapture amount is, with respect to a year, an amount equal to the difference between—

"(I) the target for the year; and

"(II) the estimated net reduction in expenditures determined under clause (i) for the year.

"(v) TARGET.—For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent of the estimated amount of expenditures under the fee schedule under this section for the year.".

(2) CONFORMING AMENDMENT.—Section 1848(c)(2)(B)(v) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(v)) is amended by adding at the end the following new subclause:

"(VIII) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2017, reduced expendi-

tures attributable to the application of the target recapture amount described in subparagraph (O)(iii).''.

(e) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—

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

''(7) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—Effective for fee schedules established beginning with 2017, for services that are not new or revised codes, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.''.

(2) CONFORMING AMENDMENTS.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)(ii)(I), by striking "subclause (II)" and inserting "subclause (II) and paragraph (7)"; and

(B) in subparagraph (K)(iii)(VI)—

(i) by striking "provisions of subparagraph (B)(ii)(II)" and inserting "provisions of subparagraph (B)(ii)(II) and paragraph (7)"; and

(ii) by striking "under subparagraph (B)(ii)(II)" and inserting "under subparagraph (B)(ii)(I)".

(f) AUTHORITY TO SMOOTH RELATIVE VALUES WITHIN GROUPS OF SERVICES.—Section 1848(c)(2)(C) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)) is amended—

(1) in each of clauses (i) and (iii), by striking "the service" and inserting "the service or group of services" each place it appears; and

(2) in the first sentence of clause (ii), by inserting "or group of services" before the period.

(g) GAO STUDY AND REPORT ON RELATIVE VALUE SCALE UPDATE COMMITTEE.—

(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the "Comptroller General") shall conduct a study of the

1 processes used by the Relative Value Scale Update
2 Committee (RUC) to provide recommendations to
3 the Secretary of Health and Human Services regard-
4 ing relative values for specific services under the
5 Medicare physician fee schedule under section 1848
6 of the Social Security Act (42 U.S.C. 1395w–4).
7 (2) REPORT.—Not later than 1 year after the
8 date of the enactment of this Act, the Comptroller
9 General shall submit to Congress a report containing
10 the results of the study conducted under paragraph
11 (1).
12 (h) ADJUSTMENT TO MEDICARE PAYMENT LOCAL-
13 ITIES.—
14 (1) IN GENERAL.—Section 1848(e) of the So-
15 cial Security Act (42 U.S.C. 1395w–4(e)) is amend-
16 ed by adding at the end the following new para-
17 graph:
18 ''(6) USE OF MSAS AS FEE SCHEDULE AREAS IN
19 CALIFORNIA.—
20 ''(A) IN GENERAL.—Subject to the suc-
21 ceeding provisions of this paragraph and not-
22 withstanding the previous provisions of this
23 subsection, for services furnished on or after
24 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 (de-

1 scribed in clause (ii)) for such year
2 multiplied by the geographic index
3 values under this subsection for the
4 fee schedule area that included such
5 MSA that would have applied in such
6 area (as estimated by the Secretary)
7 if this paragraph did not apply.
8 ''(II) MSA-BASED COMPO-
9 NENT.—The MSA-based weighting
10 factor (described in clause (iii)) for
11 such year multiplied by the geographic
12 index values computed for the fee
13 schedule area under subparagraph (A)
14 for the year (determined without re-
15 gard to this subparagraph).
16 ''(ii) OLD WEIGHTING FACTOR.—The
17 old weighting factor described in this
18 clause—
19 ''(I) for 2017, is 5/6; and
20 ''(II) for each succeeding year, is
21 the old weighting factor described in
22 this clause for the previous year
23 minus 1/6.
24 ''(iii) MSA-BASED WEIGHTING FAC-
25 TOR.—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''.

(i) DISCLOSURE OF DATA USED TO ESTABLISH MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—The Secretary of Health and Human Services shall make publicly available the information 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).

SEC. 221. MEDICAID DSH.

(a) MODIFICATIONS OF REDUCTIONS TO ALLOTMENTS.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (7)(A)—

(A) in clause (i), by striking ''2016 through 2020'' and inserting ''2017 through 2024''; and

1 (B) in clause (ii), by striking subclauses
2 (I) through (IV), and inserting the following:
3 ''(I) $1,800,000,000 for fiscal
4 year 2017;
5 ''(II) $4,700,000,000 for fiscal
6 year 2018;
7 ''(III) $4,700,000,000 for fiscal
8 year 2019;
9 ''(IV) $4,700,000,000 for fiscal
10 year 2020;
11 ''(V) $4,800,000,000 for fiscal
12 year 2021;
13 ''(VI) $5,000,000,000 for fiscal
14 year 2022;
15 ''(VII) $5,000,000,000 for fiscal
16 year 2023; and
17 ''(VIII) $4,400,000,000 for fiscal
18 year 2024.''; and
19 (2) by striking paragraph (8) and inserting the
20 following:
21 ''(8) CALCULATION OF DSH ALLOTMENTS
22 AFTER REDUCTIONS PERIOD.—The DSH allotment
23 for a State for fiscal years after fiscal year 2024
24 shall be calculated under paragraph (3) without re-
25 gard to paragraph (7).''.

1 (b) MACPAC REVIEW AND REPORT.—Section
2 1900(b)(6) of the Social Security Act (42 U.S.C.
3 1396(b)(6)) is amended—
4 (1) by striking ''MACPAC shall consult'' and
5 inserting the following:
6 ''(A) IN GENERAL.—MACPAC shall con-
7 sult''; and
8 (2) by adding at the end the following:
9 ''(B) REVIEW AND REPORTS REGARDING
10 MEDICAID DSH.—
11 ''(i) IN GENERAL.—MACPAC shall
12 review and submit an annual report to
13 Congress on disproportionate share hos-
14 pital payments under section 1923. Each
15 report shall include the information speci-
16 fied in clause (ii).
17 ''(ii) REQUIRED REPORT INFORMA-
18 TION.—Each report required under this
19 subparagraph shall include the following:
20 ''(I) Data relating to changes in
21 the number of uninsured individuals.
22 ''(II) Data relating to the
23 amount and sources of hospitals' un-
24 compensated care costs, including the
25 amount of such costs that are the re-

1 sult of providing unreimbursed or
2 under-reimbursed services, charity
3 care, or bad debt.
4 ''(III) Data identifying hospitals
5 with high levels of uncompensated
6 care that also provide access to essen-
7 tial community services for low-in-
8 come, uninsured, and vulnerable popu-
9 lations, such as graduate medical edu-
10 cation, and the continuum of primary
11 through quarternary care, including
12 the provision of trauma care and pub-
13 lic health services.
14 ''(IV) State-specific analyses re-
15 garding the relationship between the
16 most recent State DSH allotment and
17 the projected State DSH allotment for
18 the succeeding year and the data re-
19 ported under subclauses (I),(II), and
20 (III) for the State.
21 ''(iii) DATA.—Notwithstanding any
22 other provision of law, the Secretary regu-
23 larly shall provide MACPAC with the most
24 recent State reports and most recent inde-
25 pendent certified audits submitted under

1 section 1923(j), cost reports submitted
2 under title XVIII, and such other data as
3 MACPAC may request for purposes of con-
4 ducting the reviews and preparing and sub-
5 mitting the annual reports required under
6 this subparagraph.
7 ''(iv) SUBMISSION DEADLINES.—The
8 first report required under this subpara-
9 graph shall be submitted to Congress not
10 later than February 1, 2016. Subsequent
11 reports shall be submitted as part of, or
12 with, each annual report required under
13 paragraph (1)(C) during the period of fis-
14 cal years 2017 through 2024.''.

15 **SEC. 222. REALIGNMENT OF THE MEDICARE SEQUESTER**
16 **FOR FISCAL YEAR 2024.**

17 Paragraph (6) (relating to implementing direct
18 spending reductions) of section 251A of the Balanced
19 Budget and Emergency Deficit Control Act of 1985 (2
20 U.S.C. 901a) is amended by adding at the end the fol-
21 lowing new subparagraph:
22 ''(D) Notwithstanding the 2 percent limit speci-
23 fied in subparagraph (A) for payments for the Medi-
24 care programs specified in section 256(d), the se-
25 questration order of the President under such sub-

1 paragraph for fiscal year 2024 shall be applied to
2 such payments so that—
3 ''(i) with respect to the first 6 months in
4 which such order is effective for such fiscal
5 year, the payment reduction shall be 4.0 per-
6 cent; and
7 ''(ii) with respect to the second 6 months
8 in which such order is so effective for such fis-
9 cal year, the payment reduction shall be 0.0
10 percent.''.

11 **SEC. 223. DEMONSTRATION PROGRAMS TO IMPROVE COM-**
12 **MUNITY MENTAL HEALTH SERVICES.**

13 (a) CRITERIA FOR CERTIFIED COMMUNITY BEHAV-
14 IORAL HEALTH CLINICS TO PARTICIPATE IN DEM-
15 ONSTRATION PROGRAMS.—
16 (1) PUBLICATION.—Not later than September
17 1, 2015, the Secretary shall publish criteria for a
18 clinic to be certified by a State as a certified com-
19 munity behavioral health clinic for purposes of par-
20 ticipating in a demonstration program conducted
21 under subsection (d).
22 (2) REQUIREMENTS.—The criteria published
23 under this subsection shall include criteria with re-
24 spect to the following:

1 (A) STAFFING.—Staffing requirements, in-
2 cluding criteria that staff have diverse discipli-
3 nary backgrounds, have necessary State-re-
4 quired license and accreditation, and are cul-
5 turally and linguistically trained to serve the
6 needs of the clinic's patient population.
7 (B) AVAILABILITY AND ACCESSIBILITY OF
8 SERVICES.—Availability and accessibility of
9 services, including crisis management services
10 that are available and accessible 24 hours a
11 day, the use of a sliding scale for payment, and
12 no rejection for services or limiting of services
13 on the basis of a patient's ability to pay or a
14 place of residence.
15 (C) CARE COORDINATION.—Care coordina-
16 tion, including requirements to coordinate care
17 across settings and providers to ensure seamless
18 transitions for patients across the full spectrum
19 of health services including acute, chronic, and
20 behavioral health needs. Care coordination re-
21 quirements shall include partnerships or formal
22 contracts with the following:
23 (i) Federally-qualified health centers
24 (and as applicable, rural health clinics) to
25 provide Federally-qualified health center

1 services (and as applicable, rural health
2 clinic services) to the extent such services
3 are not provided directly through the cer-
4 tified community behavioral health clinic.
5 (ii) Inpatient psychiatric facilities and
6 substance use detoxification, post-detoxi-
7 fication step-down services, and residential
8 programs.
9 (iii) Other community or regional
10 services, supports, and providers, including
11 schools, child welfare agencies, juvenile and
12 criminal justice agencies and facilities, In-
13 dian Health Service youth regional treat-
14 ment centers, State licensed and nationally
15 accredited child placing agencies for thera-
16 peutic foster care service, and other social
17 and human services.
18 (iv) Department of Veterans Affairs
19 medical centers, independent outpatient
20 clinics, drop-in centers, and other facilities
21 of the Department as defined in section
22 1801 of title 38, United States Code.
23 (v) Inpatient acute care hospitals and
24 hospital outpatient clinics.

1 (D) SCOPE OF SERVICES.—Provision (in a
2 manner reflecting person-centered care) of the
3 following services which, if not available directly
4 through the certified community behavioral
5 health clinic, are provided or referred through
6 formal relationships with other providers:
7 (i) Crisis mental health services, in-
8 cluding 24-hour mobile crisis teams, emer-
9 gency crisis intervention services, and cri-
10 sis stabilization.
11 (ii) Screening, assessment, and diag-
12 nosis, including risk assessment.
13 (iii) Patient-centered treatment plan-
14 ning or similar processes, including risk as-
15 sessment and crisis planning.
16 (iv) Outpatient mental health and
17 substance use services.
18 (v) Outpatient clinic primary care
19 screening and monitoring of key health in-
20 dicators and health risk.
21 (vi) Targeted case management.
22 (vii) Psychiatric rehabilitation serv-
23 ices.
24 (viii) Peer support and counselor serv-
25 ices and family supports.

(ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

(E) QUALITY AND OTHER REPORTING.—Reporting of encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires.

(F) ORGANIZATIONAL AUTHORITY.—Criteria that a clinic be a non-profit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.), or an urban Indian organization pursuant to a grant or contract with the Indian Health Service

under title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRATION PROGRAMS.—

(1) IN GENERAL.—Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance for the establishment of a prospective payment system that shall only apply to medical assistance for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d).

(2) REQUIREMENTS.—The guidance issued by the Secretary under paragraph (1) shall provide that—

(A) no payment shall be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary; and

(B) no payment shall be made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act.

1 (c) PLANNING GRANTS.—

2 (1) IN GENERAL.—Not later than January 1,
3 2016, the Secretary shall award planning grants to
4 States for the purpose of developing proposals to
5 participate in time-limited demonstration programs
6 described in subsection (d).

7 (2) USE OF FUNDS.—A State awarded a plan-
8 ning grant under this subsection shall—

9 (A) solicit input with respect to the devel-
10 opment of such a demonstration program from
11 patients, providers, and other stakeholders;

12 (B) certify clinics as certified community
13 behavioral health clinics for purposes of partici-
14 pating in a demonstration program conducted
15 under subsection (d); and

16 (C) establish a prospective payment system
17 for mental health services furnished by a cer-
18 tified community behavioral health clinic par-
19 ticipating in a demonstration program under
20 subsection (d) in accordance with the guidance
21 issued under subsection (b).

22 (d) DEMONSTRATION PROGRAMS.—

23 (1) IN GENERAL.—Not later than September 1,
24 2017, the Secretary shall select States to participate
25 in demonstration programs that are developed

through planning grants awarded under subsection (c), meet the requirements of this subsection, and represent a diverse selection of geographic areas, including rural and underserved areas.

(2) APPLICATION REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall solicit applications to participate in demonstration programs under this subsection solely from States awarded planning grants under subsection (c).

(B) REQUIRED INFORMATION.—An application for a demonstration program under this subsection shall include the following:

(i) The target Medicaid population to be served under the demonstration program.

(ii) A list of participating certified community behavioral health clinics.

(iii) Verification that the State has certified a participating clinic as a certified community behavioral health clinic in accordance with the requirements of subsection (b).

(iv) A description of the scope of the mental health services available under the

1 State Medicaid program that will be paid
2 for under the prospective payment system
3 tested in the demonstration program.
4 (v) Verification that the State has
5 agreed to pay for such services at the rate
6 established under the prospective payment
7 system.
8 (vi) Such other information as the
9 Secretary may require relating to the dem-
10 onstration program including with respect
11 to determining the soundness of the pro-
12 posed prospective payment system.
13 (3) NUMBER AND LENGTH OF DEMONSTRATION
14 PROGRAMS.—Not more than 8 States shall be se-
15 lected for 2-year demonstration programs under this
16 subsection.
17 (4) REQUIREMENTS FOR SELECTING DEM-
18 ONSTRATION PROGRAMS.—
19 (A) IN GENERAL.—The Secretary shall
20 give preference to selecting demonstration pro-
21 grams where participating certified community
22 behavioral health clinics—
23 (i) provide the most complete scope of
24 services described in subsection (a)(2)(D)

to individuals eligible for medical assistance under the State Medicaid program;

(ii) will improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

(iii) will improve availability of, access to, and participation in assisted outpatient mental health treatment in the State; or

(iv) demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net Federal spending.

(5) PAYMENT FOR MEDICAL ASSISTANCE FOR MENTAL HEALTH SERVICES PROVIDED BY CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS.—

(A) IN GENERAL.—The Secretary shall pay a State participating in a demonstration program under this subsection the Federal matching percentage specified in subparagraph (B) for amounts expended by the State to provide medical assistance for mental health services

1 described in the demonstration program appli-
2 cation in accordance with paragraph (2)(B)(iv)
3 that are provided by certified community behav-
4 ioral health clinics to individuals who are en-
5 rolled in the State Medicaid program. Payments
6 to States made under this paragraph shall be
7 considered to have been under, and are subject
8 to the requirements of, section 1903 of the So-
9 cial Security Act (42 U.S.C. 1396b).
10 (B) FEDERAL MATCHING PERCENTAGE.—
11 The Federal matching percentage specified in
12 this subparagraph is with respect to medical as-
13 sistance described in subparagraph (A) that is
14 furnished—
15 (i) to a newly eligible individual de-
16 scribed in paragraph (2) of section 1905(y)
17 of the Social Security Act (42 U.S.C.
18 1396d(y)), the matching rate applicable
19 under paragraph (1) of that section; and
20 (ii) to an individual who is not a
21 newly eligible individual (as so described)
22 but who is eligible for medical assistance
23 under the State Medicaid program, the en-
24 hanced FMAP applicable to the State.
25 (C) LIMITATIONS.—

1 (i) IN GENERAL.—Payments shall be
2 made under this paragraph to a State only
3 for mental health services—
4 (I) that are described in the dem-
5 onstration program application in ac-
6 cordance with paragraph (2)(iv);
7 (II) for which payment is avail-
8 able under the State Medicaid pro-
9 gram; and
10 (III) that are provided to an indi-
11 vidual who is eligible for medical as-
12 sistance under the State Medicaid
13 program.
14 (ii) PROHIBITED PAYMENTS.—No
15 payment shall be made under this para-
16 graph—
17 (I) for inpatient care, residential
18 treatment, room and board expenses,
19 or any other non-ambulatory services,
20 as determined by the Secretary; or
21 (II) with respect to payments
22 made to satellite facilities of certified
23 community behavioral health clinics if
24 such facilities are established after the
25 date of enactment of this Act.

1 (6) WAIVER OF STATEWIDENESS REQUIRE-
2 MENT.—The Secretary shall waive section
3 1902(a)(1) of the Social Security Act (42 U.S.C.
4 1396a(a)(1)) (relating to statewideness) as may be
5 necessary to conduct demonstration programs in ac-
6 cordance with the requirements of this subsection.
7 (7) ANNUAL REPORTS.—
8 (A) IN GENERAL.—Not later than 1 year
9 after the date on which the first State is se-
10 lected for a demonstration program under this
11 subsection, and annually thereafter, the Sec-
12 retary shall submit to Congress an annual re-
13 port on the use of funds provided under all
14 demonstration programs conducted under this
15 subsection. Each such report shall include—
16 (i) an assessment of access to commu-
17 nity-based mental health services under the
18 Medicaid program in the area or areas of
19 a State targeted by a demonstration pro-
20 gram compared to other areas of the State;
21 (ii) an assessment of the quality and
22 scope of services provided by certified com-
23 munity behavioral health clinics compared
24 to community-based mental health services
25 provided in States not participating in a

demonstration program under this subsection and in areas of a demonstration State that are not participating in the demonstration program; and

(iii) an assessment of the impact of the demonstration programs on the Federal and State costs of a full range of mental health services (including inpatient, emergency and ambulatory services).

(B) RECOMMENDATIONS.—Not later than December 31, 2021, the Secretary shall submit to Congress recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated.

(e) DEFINITIONS.—In this section:

(1) FEDERALLY-QUALIFIED HEALTH CENTER SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC SERVICES; RURAL HEALTH CLINIC.—The terms ''Federally-qualified health center services'', ''Federally-qualified health center'', ''rural health clinic services'', and ''rural health clinic'' have the meanings given those terms in section 1905(l) of the Social Security Act (42 U.S.C. 1396d(l)).

1 (2) ENHANCED FMAP.—The term ''enhanced
2 FMAP'' has the meaning given that term in section
3 2105(b) of the Social Security Act (42 U.S.C.
4 1397dd(b) but without regard to the second and
5 third sentences of that section.
6 (3) SECRETARY.—The term ''Secretary'' means
7 the Secretary of Health and Human Services.
8 (4) STATE.—The term ''State'' has the mean-
9 ing given such term for purposes of title XIX of the
10 Social Security Act (42 U.S.C. 1396 et seq.).
11 (f) FUNDING.—
12 (1) IN GENERAL.—Out of any funds in the
13 Treasury not otherwise appropriated, there is appro-
14 priated to the Secretary—
15 (A) for purposes of carrying out sub-
16 sections (a), (b), and (d)(7), $2,000,000 for fis-
17 cal year 2014; and
18 (B) for purposes of awarding planning
19 grants under subsection (c), $25,000,000 for
20 fiscal year 2016.
21 (2) AVAILABILITY.—Funds appropriated under
22 paragraph (1) shall remain available until expended.

1 **SEC. 224. ASSISTED OUTPATIENT TREATMENT GRANT PRO-**
2 **GRAM FOR INDIVIDUALS WITH SERIOUS MEN-**
3 **TAL ILLNESS.**

4 (a) IN GENERAL.—The Secretary shall establish a 4-
5 year pilot program to award not more than 50 grants each
6 year to eligible entities for assisted outpatient treatment
7 programs for individuals with serious mental illness.

8 (b) CONSULTATION.—The Secretary shall carry out
9 this section in consultation with the Director of the Na-
10 tional Institute of Mental Health, the Attorney General
11 of the United States, the Administrator of the Administra-
12 tion for Community Living, and the Administrator of the
13 Substance Abuse and Mental Health Services Administra-
14 tion.

15 (c) SELECTING AMONG APPLICANTS.—The Sec-
16 retary—

17 (1) may only award grants under this section to
18 applicants that have not previously implemented an
19 assisted outpatient treatment program; and

20 (2) shall evaluate applicants based on their po-
21 tential to reduce hospitalization, homelessness, incar-
22 ceration, and interaction with the criminal justice
23 system while improving the health and social out-
24 comes of the patient.

1 (d) USE OF GRANT.—An assisted outpatient treat-
2 ment program funded with a grant awarded under this
3 section shall include—
4 (1) evaluating the medical and social needs of
5 the patients who are participating in the program;
6 (2) preparing and executing treatment plans for
7 such patients that—
8 (A) include criteria for completion of
9 court-ordered treatment; and
10 (B) provide for monitoring of the patient's
11 compliance with the treatment plan, including
12 compliance with medication and other treat-
13 ment regimens;
14 (3) providing for such patients case manage-
15 ment services that support the treatment plan;
16 (4) ensuring appropriate referrals to medical
17 and social service providers; and
18 (5) evaluating the process for implementing the
19 program to ensure consistency with the patient's
20 needs and State law; and
21 (6) measuring treatment outcomes, including
22 health and social outcomes such as rates of incarcer-
23 ation, health care utilization, and homelessness.
24 (e) REPORT.—Not later than the end of each of fiscal
25 years 2016, 2017, and 2018, the Secretary shall submit

1 a report to the appropriate congressional committees on
2 the grant program under this section. Each such report
3 shall include an evaluation of the following:
4 (1) Cost savings and public health outcomes
5 such as mortality, suicide, substance abuse, hos-
6 pitalization, and use of services.
7 (2) Rates of incarceration by patients.
8 (3) Rates of homelessness among patients.
9 (4) Patient and family satisfaction with pro-
10 gram participation.
11 (f) DEFINITIONS.—In this section:
12 (1) The term ''assisted outpatient treatment''
13 means medically prescribed mental health treatment
14 that a patient receives while living in a community
15 under the terms of a law authorizing a State or local
16 court to order such treatment.
17 (2) The term ''eligible entity'' means a county,
18 city, mental health system, mental health court, or
19 any other entity with authority under the law of the
20 State in which the grantee is located to implement,
21 monitor, and oversee assisted outpatient treatment
22 programs.
23 (3) The term ''Secretary'' means the Secretary
24 of Health and Human Services.
25 (g) FUNDING.—

1 (1) AMOUNT OF GRANTS.—A grant under this
2 section shall be in an amount that is not more than
3 $1,000,000 for each of fiscal years 2015 through
4 2018. Subject to the preceding sentence, the Sec-
5 retary shall determine the amount of each grant
6 based on the population of the area, including esti-
7 mated patients, to be served under the grant.
8 (2) AUTHORIZATION OF APPROPRIATIONS.—
9 There is authorized to be appropriated to carry out
10 this section $15,000,000 for each of fiscal years
11 2015 through 2018.

12 **SEC. 225. EXCLUSION FROM PAYGO SCORECARDS.**

13 (a) STATUTORY PAY-AS-YOU-GO SCORECARDS.—The
14 budgetary effects of this Act shall not be entered on either
15 PAYGO scorecard maintained pursuant to section 4(d) of
16 the Statutory Pay-As-You-Go Act of 2010.
17 (b) SENATE PAYGO SCORECARDS.—The budgetary
18 effects of this Act shall not be entered on any PAYGO
19 scorecard maintained for purposes of section 201 of S.
20 Con. Res. 21 (110th Congress).