

113<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 4302

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.

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## IN THE HOUSE OF REPRESENTATIVES

MARCH 26, 2014

Mr. PITTS introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## 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.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the  
5 “Protecting Access to Medicare Act of 2014”.

6 (b) **TABLE OF CONTENTS.**—The table of contents of  
7 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.

# 1 **TITLE I—MEDICARE EXTENDERS**

## 2 **SEC. 101. PHYSICIAN PAYMENT UPDATE.**

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

5 (1) in paragraph (15)—

6 (A) in the heading, by striking “JANUARY  
7 THROUGH MARCH OF”;

8 (B) in subparagraph (A), by striking “for  
9 the period beginning on January 1, 2014, and  
10 ending on March 31, 2014”; and

11 (C) in subparagraph (B)—

12 (i) in the heading, by striking “RE-  
13 MAINING PORTION OF 2014 AND”;

14 (ii) by striking “the period beginning  
15 on April 1, 2014, and ending on December  
16 31, 2014, and for”; and

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

19 “(16) UPDATE FOR JANUARY THROUGH MARCH  
20 OF 2015.—

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

1           tablished in paragraph (1)(C) that would other-  
2           wise apply for 2015 for the period beginning on  
3           January 1, 2015, and ending on March 31,  
4           2015, the update to the single conversion factor  
5           shall be 0.0 percent.

6           “(B) NO EFFECT ON COMPUTATION OF  
7           CONVERSION FACTOR FOR REMAINING PORTION  
8           OF 2015 AND SUBSEQUENT YEARS.—The con-  
9           version factor under this subsection shall be  
10          computed under paragraph (1)(A) for the pe-  
11          riod beginning on April 1, 2015, and ending on  
12          December 31, 2015, and for 2016 and subse-  
13          quent years as if subparagraph (A) had never  
14          applied.”.

15 **SEC. 102. EXTENSION OF WORK GPCI FLOOR.**

16          Section 1848(e)(1)(E) of the Social Security Act (42  
17 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “April  
18 1, 2014” and inserting “April 1, 2015”.

19 **SEC. 103. EXTENSION OF THERAPY CAP EXCEPTIONS PROC-**  
20 **ESS.**

21          Section 1833(g) of the Social Security Act (42 U.S.C.  
22 1395l(g)) is amended—

23               (1) in paragraph (5)(A), in the first sentence,  
24               by striking “March 31, 2014” and inserting “March  
25               31, 2015”; and

1 (2) in paragraph (6)(A)—

2 (A) by striking “March 31, 2014” and in-  
3 serting “March 31, 2015”; and

4 (B) by striking “2012, 2013, or the first  
5 three months of 2014” and inserting “2012,  
6 2013, 2014, or the first three months of 2015”.

7 **SEC. 104. EXTENSION OF AMBULANCE ADD-ONS.**

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

12 (b) SUPER RURAL GROUND AMBULANCE.—Section  
13 1834(l)(12)(A) of the Social Security Act (42 U.S.C.  
14 1395m(l)(12)(A)) is amended, in the first sentence, by  
15 striking “April 1, 2014” and inserting “April 1, 2015”.

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

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

21 (1) in subparagraph (B), in the matter pre-  
22 ceding clause (i), by striking “in the portion of fiscal  
23 year 2014 beginning on April 1, 2014, fiscal year  
24 2015, and subsequent fiscal years” and inserting “in

1 fiscal year 2015 (beginning on April 1, 2015), fiscal  
2 year 2016, and subsequent fiscal years”;

3 (2) in subparagraph (C)(i), by striking “fiscal  
4 years 2011, 2012, and 2013, and the portion of fis-  
5 cal year 2014 before” and inserting “fiscal years  
6 2011 through 2014 and fiscal year 2015 (before  
7 April 1, 2015),” each place it appears; and

8 (3) in subparagraph (D), by striking “fiscal  
9 years 2011, 2012, and 2013, and the portion of fis-  
10 cal year 2014 before April 1, 2014,” and inserting  
11 “fiscal years 2011 through 2014 and fiscal year  
12 2015 (before April 1, 2015),”.

13 **SEC. 106. EXTENSION OF THE MEDICARE-DEPENDENT HOS-**  
14 **PITAL (MDH) PROGRAM.**

15 (a) IN GENERAL.—Section 1886(d)(5)(G) of the So-  
16 cial Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amend-  
17 ed—

18 (1) in clause (i), by striking “April 1, 2014”  
19 and inserting “April 1, 2015”; and

20 (2) in clause (ii)(II), by striking “April 1,  
21 2014” and inserting “April 1, 2015”.

22 (b) CONFORMING AMENDMENTS.—

23 (1) EXTENSION OF TARGET AMOUNT.—Section  
24 1886(b)(3)(D) of the Social Security Act (42 U.S.C.  
25 1395ww(b)(3)(D)) is amended—

1 (A) in the matter preceding clause (i), by  
2 striking “April 1, 2014” and inserting “April 1,  
3 2015”; and

4 (B) in clause (iv), by striking “through fis-  
5 cal year 2013 and the portion of fiscal year  
6 2014 before April 1, 2014” and inserting  
7 “through fiscal year 2014 and the portion of  
8 fiscal year 2015 before April 1, 2015”.

9 (2) PERMITTING HOSPITALS TO DECLINE RE-  
10 CLASSIFICATION.—Section 13501(e)(2) of the Omni-  
11 bus Budget Reconciliation Act of 1993 (42 U.S.C.  
12 1395ww note) is amended by striking “through the  
13 first 2 quarters of fiscal year 2014” and inserting  
14 “through the first 2 quarters of fiscal year 2015”.

15 **SEC. 107. EXTENSION FOR SPECIALIZED MEDICARE ADVAN-**  
16 **TAGE PLANS FOR SPECIAL NEEDS INDIVID-**  
17 **UALS.**

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

21 **SEC. 108. EXTENSION OF MEDICARE REASONABLE COST**  
22 **CONTRACTS.**

23 Section 1876(h)(5)(C)(ii) of the Social Security Act  
24 (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the mat-

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

3 **SEC. 109. EXTENSION OF FUNDING FOR QUALITY MEASURE**

4 **ENDORSEMENT, INPUT, AND SELECTION.**

5 Section 1890(d) of the Social Security Act (42 U.S.C.  
6 1395aaa(d)) is amended—

7 (1) by inserting “(1)” before “For purposes”;

8 and

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

11 “(2) For purposes of carrying out this section and  
12 section 1890A (other than subsections (e) and (f)), the  
13 Secretary shall provide for the transfer, from the Federal  
14 Hospital Insurance Trust Fund under section 1817 and  
15 the Federal Supplementary Medical Insurance Trust  
16 Fund under section 1841, in such proportion as the Sec-  
17 retary determines appropriate, to the Centers for Medicare  
18 & Medicaid Services Program Management Account of  
19 \$5,000,000 for fiscal year 2014 and \$15,000,000 for the  
20 first 6 months of fiscal year 2015. Amounts transferred  
21 under the preceding sentence shall remain available until  
22 expended.”.



1 **SEC. 110. EXTENSION OF FUNDING OUTREACH AND ASSIST-**  
2 **ANCE FOR LOW-INCOME PROGRAMS.**

3 (a) **ADDITIONAL FUNDING FOR STATE HEALTH IN-**  
4 **SURANCE PROGRAMS.**—Subsection (a)(1)(B) of section  
5 119 of the Medicare Improvements for Patients and Pro-  
6 viders Act of 2008 (42 U.S.C. 1395b–3 note), as amended  
7 by section 3306 of the Patient Protection and Affordable  
8 Care Act Public Law 111–148), section 610 of the Amer-  
9 ican Taxpayer Relief Act of 2012 (Public Law 112–240),  
10 and section 1110 of the Pathway for SGR Reform Act  
11 of 2013 (Public Law 113–67), is amended—

12 (1) in clause (iii), by striking “and” at the end;

13 (2) by striking clause (iv); and

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

16 “(iv) for fiscal year 2014, of  
17 \$7,500,000; and

18 “(v) for the portion of fiscal year  
19 2015 before April 1, 2015, of  
20 \$3,750,000.”.

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

24 (1) in clause (iii), by striking “and” at the end;

25 (2) by striking clause (iv); and

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

3                   “(iv) for fiscal year 2014, of  
4                   \$7,500,000; and

5                   “(v) for the portion of fiscal year  
6                   2015 before April 1, 2015, of  
7                   \$3,750,000.”.

8           (c) ADDITIONAL FUNDING FOR AGING AND DIS-  
9 ABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of  
10 such section 119, as so amended, is amended—

11           (1) in clause (iii), by striking “and” at the end;

12           (2) by striking clause (iv); and

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

15                   “(iv) for fiscal year 2014, of  
16                   \$5,000,000; and

17                   “(v) for the portion of fiscal year  
18                   2015 before April 1, 2015, of  
19                   \$2,500,000.”.

20           (d) ADDITIONAL FUNDING FOR CONTRACT WITH  
21 THE NATIONAL CENTER FOR BENEFITS AND OUTREACH  
22 ENROLLMENT.—Subsection (d)(2) of such section 119, as  
23 so amended, is amended—

24           (1) in clause (iii), by striking “and” at the end;

25           (2) by striking clause (iv); and

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

3                       “(iv) for fiscal year 2014, of  
4                       \$5,000,000; and

5                       “(v) for the portion of fiscal year  
6                       2015 before April 1, 2015, of  
7                       \$2,500,000.”.

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

9       (a) CONTINUATION OF CERTAIN MEDICAL REVIEW  
10   ACTIVITIES.—The Secretary of Health and Human Serv-  
11   ices may continue medical review activities described in  
12   the notice entitled “Selecting Hospital Claims for Patient  
13   Status Reviews: Admissions On or After October 1,  
14   2013”, posted on the Internet website of the Centers for  
15   Medicare & Medicaid Services, through the first 6 months  
16   of fiscal year 2015 for such additional hospital claims as  
17   the Secretary determines appropriate.

18       (b) LIMITATION.—The Secretary of Health and  
19   Human Services shall not conduct patient status reviews  
20   (as described in such notice) on a post-payment review  
21   basis through recovery audit contractors under section  
22   1893(h) of the Social Security Act (42 U.S.C.  
23   1395ddd(h)) for inpatient claims with dates of admission  
24   October 1, 2013, through March 31, 2015, unless there  
25   is evidence of systematic gaming, fraud, abuse, or delays

1 in the provision of care by a provider of services (as de-  
2 fined in section 1861(u) of such Act (42 U.S.C.  
3 1395x(u))).

4 **SEC. 112. TECHNICAL CHANGES TO MEDICARE LTCH**  
5 **AMENDMENTS.**

6 (a) IN GENERAL.—Subclauses (I) and (II) of section  
7 1886(m)(6)(C)(iv) of the Social Security Act (42 U.S.C.  
8 1395ww(m)(6)(C)(iv)) are each amended by striking “dis-  
9 charges” and inserting “Medicare fee-for-service dis-  
10 charges”.

11 (b) MMSEA CORRECTION.—Section 114(d) of the  
12 Medicare, Medicaid, and SCHIP Extension Act of 2007  
13 (42 U.S.C. 1395ww note), as amended by sections 3106(b)  
14 and 10312(b) of Public Law 111–148 and by section  
15 1206(b)(2) of the Pathway for SGR Reform Act of 2013  
16 (division B of Public Law 113–67), is amended—

17 (1) in paragraph (1), in the matter preceding  
18 subparagraph (A), by striking “January 1, 2015,”  
19 and inserting “on the date of the enactment of para-  
20 graph (7) of this subsection”;

21 (2) in paragraph (6), by striking “January 1,  
22 2015,” and inserting “on the date of the enactment  
23 of paragraph (7) of this subsection”; and

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

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

5           “(A) began its qualifying period for pay-  
6 ment as a long-term care hospital under section  
7 412.23(e) of title 42, Code of Federal Regula-  
8 tions, on or before the date of enactment of this  
9 paragraph;

10           “(B) has a binding written agreement as  
11 of the date of the enactment of this paragraph  
12 with an outside, unrelated party for the actual  
13 construction, renovation, lease, or demolition  
14 for a long-term care hospital, and has ex-  
15 pended, before such date of enactment, at least  
16 10 percent of the estimated cost of the project  
17 (or, if less, \$2,500,000); or

18           “(C) has obtained an approved certificate  
19 of need in a State where one is required on or  
20 before such date of enactment.”.

21           (c) ADDITIONAL AMENDMENTS.—Section 1206(a) of  
22 the Pathway for SGR Reform Act of 2013 (division B of  
23 Public Law 113–67) is amended—

24           (1) in paragraph (2)(A), by striking “Assess-  
25 ment” and inserting “Advisory”; and

1           (2) in paragraph (3)(B), by striking “shall not  
2           apply to a hospital that is classified as of December  
3           10, 2013, as a subsection (d) hospital (as defined in  
4           section 1886(d)(1)(B) of the Social Security Act, 42  
5           U.S.C. 1395ww(d)(1)(B))” and inserting “shall only  
6           apply to a hospital that is classified as of December  
7           10, 2013, as a long-term care hospital (as defined  
8           in section 1861(ccc) of the Social Security Act, 42  
9           U.S.C. 1395x(ccc))”.

10          (d) EFFECTIVE DATE.—The amendments made by  
11 this section are effective as of the date of the enactment  
12 of this Act.

## 13                   **TITLE II—OTHER HEALTH** 14                   **PROVISIONS**

### 15   **SEC. 201. EXTENSION OF THE QUALIFYING INDIVIDUAL (QI)** 16                   **PROGRAM.**

17          (a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the  
18 Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is  
19 amended by striking “March 2014” and inserting “March  
20 2015”.

21          (b) EXTENDING TOTAL AMOUNT AVAILABLE FOR  
22 ALLOCATION.—Section 1933(g) of the Social Security Act  
23 (42 U.S.C. 1396u–3(g)) is amended—

24                   (1) in paragraph (2)—

1 (A) in subparagraph (T), by striking  
2 “and” at the end;

3 (B) in subparagraph (U)—

4 (i) by striking “March 31, 2014” and  
5 inserting “September 30, 2014”; and

6 (ii) by striking “\$200,000,000.” and  
7 inserting “\$485,000,000;” and

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

10 “(V) for the period that begins on October  
11 1, 2014, and ends on December 31, 2014, the  
12 total allocation amount is \$300,000,000; and

13 “(W) for the period that begins on Janu-  
14 ary 1, 2015, and ends on March 31, 2015, the  
15 total allocation amount is \$250,000,000.”; and

16 (2) in paragraph (3), in the matter preceding  
17 subparagraph (A), by striking “or (T)” and insert-  
18 ing “(T), or (V)”.

19 **SEC. 202. TEMPORARY EXTENSION OF TRANSITIONAL MED-**  
20 **ICAL ASSISTANCE (TMA).**

21 Sections 1902(e)(1)(B) and 1925(f) of the Social Se-  
22 curity Act (42 U.S.C. 1396a(e)(1)(B), 1396r-6(f)) are  
23 each amended by striking “March 31, 2014” and inserting  
24 “March 31, 2015”.

1 **SEC. 203. EXTENSION OF MEDICAID AND CHIP EXPRESS**

2 **LANE OPTION.**

3 Section 1902(e)(13)(I) of the Social Security Act (42  
4 U.S.C. 1396a(e)(13)(I)) is amended by striking “Sep-  
5 tember 30, 2014” and inserting “September 30, 2015”.

6 **SEC. 204. EXTENSION OF SPECIAL DIABETES PROGRAM**

7 **FOR TYPE I DIABETES AND FOR INDIANS.**

8 (a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-  
9 BETES.—Section 330B(b)(2)(C) of the Public Health  
10 Service Act (42 U.S.C. 254e–2(b)(2)(C)) is amended by  
11 striking “2014” and inserting “2015”.

12 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—  
13 Section 330C(c)(2)(C) of the Public Health Service Act  
14 (42 U.S.C. 254e–3(c)(2)(C)) is amended by striking  
15 “2014” and inserting “2015”.

16 **SEC. 205. EXTENSION OF ABSTINENCE EDUCATION.**

17 Subsections (a) and (d) of section 510 of the Social  
18 Security Act (42 U.S.C. 710) are each amended by strik-  
19 ing “2014” and inserting “2015”.

20 **SEC. 206. EXTENSION OF PERSONAL RESPONSIBILITY EDU-**

21 **CATION PROGRAM (PREP).**

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

24 (1) in paragraphs (1)(A) and (4)(A) of sub-  
25 section (a), by striking “2014” and inserting  
26 “2015” each place it appears;



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

3           (3) in subsection (f), by striking “2014” and  
4           inserting “2015”.

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

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

9           (1) in clause (iii), by striking at the end “and”;

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

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

15           “(v) \$2,500,000 for the portion of fiscal year  
16           2014 on or after April 1, 2014; and

17           “(vi) \$2,500,000 for the portion of fiscal year  
18           2015 before April 1, 2015.”.

19 **SEC. 208. EXTENSION OF HEALTH WORKFORCE DEM-**  
20 **ONSTRATION PROJECT FOR LOW-INCOME IN-**  
21 **DIVIDUALS.**

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

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

3 Section 511(j) of the Social Security Act (42 U.S.C.  
4 711(j)) is amended—

5 (1) in paragraph (1)—

6 (A) by striking “and” at the end of sub-  
7 paragraph (D);

8 (B) by striking the period at the end of  
9 subparagraph (E) and inserting “; and”; and

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

12 “(F) for the period beginning on October  
13 1, 2014, and ending on March 31, 2015, an  
14 amount equal to the amount provided in sub-  
15 paragraph (E).”; and

16 (2) in paragraphs (2) and (3), by inserting “(or  
17 portion of a fiscal year)” after “for a fiscal year”  
18 each place it appears.

19 **SEC. 210. PEDIATRIC QUALITY MEASURES.**

20 (a) CONTINUATION OF FUNDING FOR PEDIATRIC  
21 QUALITY MEASURES FOR IMPROVING THE QUALITY OF  
22 CHILDREN’S HEALTH CARE.—Section 1139B(e) of the  
23 Social Security Act (42 U.S.C. 1320b–9b(e)) is amended  
24 by adding at the end the following: “Of the funds appro-  
25 priated under this subsection, not less than \$15,000,000  
26 shall be used to carry out section 1139A(b).”.

1 (b) ELIMINATION OF RESTRICTION ON MEDICAID  
2 QUALITY MEASUREMENT PROGRAM.—Section  
3 1139B(b)(5)(A) of the Social Security Act (42 U.S.C.  
4 1320b–9b(b)(5)(A)) is amended by striking “The aggre-  
5 gate amount awarded by the Secretary for grants and con-  
6 tracts for the development, testing, and validation of  
7 emerging and innovative evidence-based measures under  
8 such program shall equal the aggregate amount awarded  
9 by the Secretary for grants under section  
10 1139A(b)(4)(A)”.

11 **SEC. 211. DELAY OF EFFECTIVE DATE FOR MEDICAID**  
12 **AMENDMENTS RELATING TO BENEFICIARY**  
13 **LIABILITY SETTLEMENTS.**

14 Effective as if included in the enactment of the Bipar-  
15 tisan Budget Act of 2013 (Public Law 113–67), section  
16 202(c) of such Act is amended by striking “October 1,  
17 2014” and inserting “October 1, 2016”.

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

20 The Secretary of Health and Human Services may  
21 not, prior to October 1, 2015, adopt ICD–10 code sets  
22 as the standard for code sets under section 1173(c) of the  
23 Social Security Act (42 U.S.C. 1320d–2(c)) and section  
24 162.1002 of title 45, Code of Federal Regulations.

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

3 (a) IN GENERAL.—Section 1302(c) of the Patient  
4 Protection and Affordable Care Act (Public Law 111–148;  
5 42 U.S.C. 18022(c)) is amended—

6 (1) by striking paragraph (2); and

7 (2) in paragraph (4)(A), by striking “para-  
8 graphs (1)(B)(i) and (2)(B)(i)” and inserting “para-  
9 graph (1)(B)(i)”.

10 (b) CONFORMING AMENDMENT.—Section 2707(b) of  
11 the Public Health Service Act (42 U.S.C. 300gg–6(b)) is  
12 amended by striking “paragraphs (1) and (2)” and insert-  
13 ing “paragraph (1)”.

14 (c) EFFECTIVE DATE.—The amendments made by  
15 this Act shall be effective as if included in the enactment  
16 of the Patient Protection and Affordable Care Act (Public  
17 Law 111–148).

18 **SEC. 214. GAO REPORT ON THE CHILDREN’S HOSPITAL**  
19 **GRADUATE MEDICAL EDUCATION PROGRAM.**

20 (a) IN GENERAL.—In the case that the Children’s  
21 Hospital GME Support Reauthorization Act of 2013 is en-  
22 acted into law, the Comptroller General of the United  
23 States shall, not later than November 30, 2017, conduct  
24 an independent evaluation, and submit to the appropriate  
25 committees of Congress a report, concerning the imple-  
26 mentation of section 340E(h) of the Public Health Service

1 Act, as added by section 3 of the Children’s Hospital GME  
2 Support Reauthorization Act of 2013.

3 (b) CONTENT.—The report described in subsection  
4 (a) shall review and assess each of the following, with re-  
5 spect to hospitals receiving payments under such section  
6 340E(h) during the period of fiscal years 2015 through  
7 2017:

8 (1) The number and type of such hospitals that  
9 applied for such payments.

10 (2) The number and type of such hospitals re-  
11 ceiving such payments.

12 (3) The amount of such payments awarded to  
13 such hospitals.

14 (4) How such hospitals used such payments.

15 (5) The impact of such payments on—

16 (A) the number of pediatric providers; and

17 (B) health care needs of children.

18 **SEC. 215. SKILLED NURSING FACILITY VALUE-BASED PUR-**

19 **CHASING.**

20 (a) IN GENERAL.—Section 1888 of the Social Secu-  
21 rity Act (42 U.S.C. 1395yy) is amended by adding at the  
22 end the following new subsection:

23 “(g) SKILLED NURSING FACILITY READMISSION  
24 MEASURE.—

1           “(1) READMISSION MEASURE.—Not later than  
2           October 1, 2015, the Secretary shall specify a skilled  
3           nursing facility all-cause all-condition hospital read-  
4           mission measure (or any successor to such a meas-  
5           ure).

6           “(2) RESOURCE USE MEASURE.—Not later than  
7           October 1, 2016, the Secretary shall specify a meas-  
8           ure to reflect an all-condition risk-adjusted poten-  
9           tially preventable hospital readmission rate for  
10          skilled nursing facilities.

11          “(3) MEASURE ADJUSTMENTS.—When speci-  
12          fying the measures under paragraphs (1) and (2),  
13          the Secretary shall devise a methodology to achieve  
14          a high level of reliability and validity, especially for  
15          skilled nursing facilities with a low volume of re-  
16          admissions.

17          “(4) PRE-RULEMAKING PROCESS (MEASURE AP-  
18          PLICATION PARTNERSHIP PROCESS).—The applica-  
19          tion of the provisions of section 1890A shall be op-  
20          tional in the case of a measure specified under para-  
21          graph (1) and a measure specified under paragraph  
22          (2).

23          “(5) FEEDBACK REPORTS TO SKILLED NURS-  
24          ING FACILITIES.—Beginning October 1, 2016, and  
25          every quarter thereafter, the Secretary shall provide

1 confidential feedback reports to skilled nursing fa-  
2 cilities on the performance of such facilities with re-  
3 spect to a measure specified under paragraph (1) or  
4 (2).

5 “(6) PUBLIC REPORTING OF SKILLED NURSING  
6 FACILITIES.—

7 “(A) IN GENERAL.—Subject to subpara-  
8 graphs (B) and (C), the Secretary shall estab-  
9 lish procedures for making available to the pub-  
10 lic by posting on the Nursing Home Compare  
11 Medicare website (or a successor website) de-  
12 scribed in section 1819(i) information on the  
13 performance of skilled nursing facilities with re-  
14 spect to a measure specified under paragraph  
15 (1) and a measure specified under paragraph  
16 (2).

17 “(B) OPPORTUNITY TO REVIEW.—The pro-  
18 cedures under subparagraph (A) shall ensure  
19 that a skilled nursing facility has the oppor-  
20 tunity to review and submit corrections to the  
21 information that is to be made public with re-  
22 spect to the facility prior to such information  
23 being made public.

24 “(C) TIMING.—Such procedures shall pro-  
25 vide that the information described in subpara-

1 graph (A) is made publicly available beginning  
2 not later than October 1, 2017.

3 “(7) NON-APPLICATION OF PAPERWORK REDUC-  
4 TION ACT.—Chapter 35 of title 44, United States  
5 Code (commonly referred to as the ‘Paperwork Re-  
6 duction Act of 1995’) shall not apply to this sub-  
7 section.”.

8 (b) VALUE-BASED PURCHASING PROGRAM FOR  
9 SKILLED NURSING FACILITIES.—Section 1888 of the So-  
10 cial Security Act (42 U.S.C. 1395yy), as amended by sub-  
11 section (a), is further amended by adding at the end the  
12 following new subsection:

13 “(h) SKILLED NURSING FACILITY VALUE-BASED  
14 PURCHASING PROGRAM.—

15 “(1) ESTABLISHMENT.—

16 “(A) IN GENERAL.—Subject to the suc-  
17 ceeding provisions of this subsection, the Sec-  
18 retary shall establish a skilled nursing facility  
19 value-based purchasing program (in this sub-  
20 section referred to as the ‘SNF VBP Program’)  
21 under which value-based incentive payments are  
22 made in a fiscal year to skilled nursing facili-  
23 ties.

24 “(B) PROGRAM TO BEGIN IN FISCAL YEAR  
25 2019.—The SNF VBP Program shall apply to



1 payments for services furnished on or after Oc-  
2 tober 1, 2018.

3 “(2) APPLICATION OF MEASURES.—

4 “(A) IN GENERAL.—The Secretary shall  
5 apply the measure specified under subsection  
6 (g)(1) for purposes of the SNF VBP Program.

7 “(B) REPLACEMENT.—For purposes of the  
8 SNF VBP Program, the Secretary shall apply  
9 the measure specified under (g)(2) instead of  
10 the measure specified under (g)(1) as soon as  
11 practicable.

12 “(3) PERFORMANCE STANDARDS.—

13 “(A) ESTABLISHMENT.—The Secretary  
14 shall establish performance standards with re-  
15 spect to the measure applied under paragraph  
16 (2) for a performance period for a fiscal year.

17 “(B) HIGHER OF ACHIEVEMENT AND IM-  
18 PROVEDMENT.—The performance standards es-  
19 tablished under subparagraph (A) shall include  
20 levels of achievement and improvement. In cal-  
21 culating the SNF performance score under  
22 paragraph (4), the Secretary shall use the high-  
23 er of either improvement or achievement.

24 “(C) TIMING.—The Secretary shall estab-  
25 lish and announce the performance standards

1 established under subparagraph (A) not later  
2 than 60 days prior to the beginning of the per-  
3 formance period for the fiscal year involved.

4 “(4) SNF PERFORMANCE SCORE.—

5 “(A) IN GENERAL.—The Secretary shall  
6 develop a methodology for assessing the total  
7 performance of each skilled nursing facility  
8 based on performance standards established  
9 under paragraph (3) with respect to the meas-  
10 ure applied under paragraph (2). Using such  
11 methodology, the Secretary shall provide for an  
12 assessment (in this subsection referred to as the  
13 ‘SNF performance score’) for each skilled nurs-  
14 ing facility for each such performance period.

15 “(B) RANKING OF SNF PERFORMANCE  
16 SCORES.—The Secretary shall, for the perform-  
17 ance period for each fiscal year, rank the SNF  
18 performance scores determined under subpara-  
19 graph (A) from low to high.

20 “(5) CALCULATION OF VALUE-BASED INCEN-  
21 TIVE PAYMENTS.—

22 “(A) IN GENERAL.—With respect to a  
23 skilled nursing facility, based on the ranking  
24 under paragraph (4)(B) for a performance pe-  
25 riod for a fiscal year, the Secretary shall in-

1           crease the adjusted Federal per diem rate de-  
2           termined under subsection (e)(4)(G) otherwise  
3           applicable to such skilled nursing facility (and  
4           after application of paragraph (6)) for services  
5           furnished by such facility during such fiscal  
6           year by the value-based incentive payment  
7           amount under subparagraph (B).

8           “(B) VALUE-BASED INCENTIVE PAYMENT  
9           AMOUNT.—The value-based incentive payment  
10          amount for services furnished by a skilled nurs-  
11          ing facility in a fiscal year shall be equal to the  
12          product of—

13               “(i) the adjusted Federal per diem  
14               rate determined under subsection (e)(4)(G)  
15               otherwise applicable to such skilled nursing  
16               facility for such services furnished by the  
17               skilled nursing facility during such fiscal  
18               year; and

19               “(ii) the value-based incentive pay-  
20               ment percentage specified under subpara-  
21               graph (C) for the skilled nursing facility  
22               for such fiscal year.

23           “(C) VALUE-BASED INCENTIVE PAYMENT  
24          PERCENTAGE.—

1           “(i) IN GENERAL.—The Secretary  
2 shall specify a value-based incentive pay-  
3 ment percentage for a skilled nursing facil-  
4 ity for a fiscal year which may include a  
5 zero percentage.

6           “(ii) REQUIREMENTS.—In specifying  
7 the value-based incentive payment percent-  
8 age for each skilled nursing facility for a  
9 fiscal year under clause (i), the Secretary  
10 shall ensure that—

11           “(I) such percentage is based on  
12 the SNF performance score of the  
13 skilled nursing facility provided under  
14 paragraph (4) for the performance pe-  
15 riod for such fiscal year;

16           “(II) the application of all such  
17 percentages in such fiscal year results  
18 in an appropriate distribution of  
19 value-based incentive payments under  
20 subparagraph (B) such that—

21           “(aa) skilled nursing facili-  
22 ties with the highest rankings  
23 under paragraph (4)(B) receive  
24 the highest value-based incentive

1 payment amounts under subpara-  
2 graph (B);

3 “(bb) skilled nursing facili-  
4 ties with the lowest rankings  
5 under paragraph (4)(B) receive  
6 the lowest value-based incentive  
7 payment amounts under subpara-  
8 graph (B); and

9 “(cc) in the case of skilled  
10 nursing facilities in the lowest 40  
11 percent of the ranking under  
12 paragraph (4)(B), the payment  
13 rate under subparagraph (A) for  
14 services furnished by such facility  
15 during such fiscal year shall be  
16 less than the payment rate for  
17 such services for such fiscal year  
18 that would otherwise apply under  
19 subsection (e)(4)(G) without ap-  
20 plication of this subsection; and

21 “(III) the total amount of value-  
22 based incentive payments under this  
23 paragraph for all skilled nursing fa-  
24 cilities in such fiscal year shall be  
25 greater than or equal to 50 percent,

1 but not greater than 70 percent, of  
2 the total amount of the reductions to  
3 payments for such fiscal year under  
4 paragraph (6), as estimated by the  
5 Secretary.

6 “(6) FUNDING FOR VALUE-BASED INCENTIVE  
7 PAYMENTS.—

8 “(A) IN GENERAL.—The Secretary shall  
9 reduce the adjusted Federal per diem rate de-  
10 termined under subsection (e)(4)(G) otherwise  
11 applicable to a skilled nursing facility for serv-  
12 ices furnished by such facility during a fiscal  
13 year (beginning with fiscal year 2019) by the  
14 applicable percent (as defined in subparagraph  
15 (B)). The Secretary shall make such reductions  
16 for all skilled nursing facilities in the fiscal year  
17 involved, regardless of whether or not the  
18 skilled nursing facility has been determined by  
19 the Secretary to have earned a value-based in-  
20 centive payment under paragraph (5) for such  
21 fiscal year.

22 “(B) APPLICABLE PERCENT.—For pur-  
23 poses of subparagraph (A), the term ‘applicable  
24 percent’ means, with respect to fiscal year 2019  
25 and succeeding fiscal years, 2 percent.

1           “(7) ANNOUNCEMENT OF NET RESULT OF AD-  
2 JUSTMENTS.—Under the SNF VBP Program, the  
3 Secretary shall, not later than 60 days prior to the  
4 fiscal year involved, inform each skilled nursing fa-  
5 cility of the adjustments to payments to the skilled  
6 nursing facility for services furnished by such facility  
7 during the fiscal year under paragraphs (5) and (6).

8           “(8) NO EFFECT IN SUBSEQUENT FISCAL  
9 YEARS.—The value-based incentive payment under  
10 paragraph (5) and the payment reduction under  
11 paragraph (6) shall each apply only with respect to  
12 the fiscal year involved, and the Secretary shall not  
13 take into account such value-based incentive pay-  
14 ment or payment reduction in making payments to  
15 a skilled nursing facility under this section in a sub-  
16 sequent fiscal year.

17           “(9) PUBLIC REPORTING.—

18           “(A) SNF SPECIFIC INFORMATION.—The  
19 Secretary shall make available to the public, by  
20 posting on the Nursing Home Compare Medi-  
21 care website (or a successor website) described  
22 in section 1819(i) in an easily understandable  
23 format, information regarding the performance  
24 of individual skilled nursing facilities under the

1 SNF VBP Program, with respect to a fiscal  
2 year, including—

3 “(i) the SNF performance score of the  
4 skilled nursing facility for such fiscal year;  
5 and

6 “(ii) the ranking of the skilled nursing  
7 facility under paragraph (4)(B) for the  
8 performance period for such fiscal year.

9 “(B) AGGREGATE INFORMATION.—The  
10 Secretary shall periodically post on the Nursing  
11 Home Compare Medicare website (or a suc-  
12 cessor website) described in section 1819(i) ag-  
13 gregate information on the SNF VBP Program,  
14 including—

15 “(i) the range of SNF performance  
16 scores provided under paragraph (4)(A);  
17 and

18 “(ii) the number of skilled nursing fa-  
19 cilities receiving value-based incentive pay-  
20 ments under paragraph (5) and the range  
21 and total amount of such value-based in-  
22 centive payments.

23 “(10) LIMITATION ON REVIEW.—There shall be  
24 no administrative or judicial review under section  
25 1869, section 1878, or otherwise of the following:



1           “(A) The methodology used to determine  
2           the value-based incentive payment percentage  
3           and the amount of the value-based incentive  
4           payment under paragraph (5).

5           “(B) The determination of the amount of  
6           funding available for such value-based incentive  
7           payments under paragraph (5)(C)(ii)(III) and  
8           the payment reduction under paragraph (6).

9           “(C) The establishment of the performance  
10          standards under paragraph (3) and the per-  
11          formance period.

12          “(D) The methodology developed under  
13          paragraph (4) that is used to calculate SNF  
14          performance scores and the calculation of such  
15          scores.

16          “(E) The ranking determinations under  
17          paragraph (4)(B).

18          “(11) FUNDING FOR PROGRAM MANAGE-  
19          MENT.—The Secretary shall provide for the one time  
20          transfer from the Federal Hospital Insurance Trust  
21          Fund established under section 1817 to the Centers  
22          for Medicare & Medicaid Services Program Manage-  
23          ment Account of—

24                  “(A) for purposes of subsection (g)(2),  
25                  \$2,000,000; and

1                   “(B) for purposes of implementing this  
2                   subsection, \$10,000,000.

3                   Such funds shall remain available until expended.”.

4                   (c) MEDPAC STUDY.—Not later than June 30,  
5 2021, the Medicare Payment Advisory Commission shall  
6 submit to Congress a report that reviews the progress of  
7 the skilled nursing facility value-based purchasing pro-  
8 gram established under section 1888(h) of the Social Se-  
9 curity Act, as added by subsection (b), and makes rec-  
10 ommendations, as appropriate, on any improvements that  
11 should be made to such program. For purposes of the pre-  
12 vious sentence, the Medicare Payment Advisory Commis-  
13 sion shall consider any unintended consequences with re-  
14 spect to such skilled nursing facility value-based pur-  
15 chasing program and any potential adjustments to the re-  
16 admission measure specified under section 1888(g)(1) of  
17 such Act, as added by subsection (a), for purposes of de-  
18 termining the effect of the socio-economic status of a bene-  
19 ficiary under the Medicare program under title XVIII of  
20 the Social Security Act for the SNF performance score  
21 of a skilled nursing facility provided under section  
22 1888(h)(4) of such Act, as added by subsection (b).

1 **SEC. 216. IMPROVING MEDICARE POLICIES FOR CLINICAL**  
2 **DIAGNOSTIC LABORATORY TESTS.**

3 (a) IN GENERAL.—Title XVIII of the Social Security  
4 Act is amended by inserting after section 1834 (42 U.S.C.  
5 1395m) the following new section:

6 **“SEC. 1834A. IMPROVING POLICIES FOR CLINICAL DIAG-**  
7 **NOSTIC LABORATORY TESTS.**

8 “(a) REPORTING OF PRIVATE SECTOR PAYMENT  
9 RATES FOR ESTABLISHMENT OF MEDICARE PAYMENT  
10 RATES.—

11 “(1) IN GENERAL.—Beginning January 1,  
12 2016, and every 3 years thereafter (or, annually, in  
13 the case of reporting with respect to an advanced di-  
14 agnostic laboratory test, as defined in subsection  
15 (d)(5)), an applicable laboratory (as defined in para-  
16 graph (2)) shall report to the Secretary, at a time  
17 specified by the Secretary, applicable information (as  
18 defined in paragraph (3)) for a data collection pe-  
19 riod (as defined in paragraph (4)) for each clinical  
20 diagnostic laboratory test that the laboratory fur-  
21 nishes during such period for which payment is  
22 made under this part.

23 “(2) DEFINITION OF APPLICABLE LABORA-  
24 TORY.—In this section, the term ‘applicable labora-  
25 tory’ means a laboratory that, with respect to its  
26 revenues under this title, a majority of such reve-

1 nues are from this section, section 1833(h), or sec-  
2 tion 1848. The Secretary may establish a low vol-  
3 ume or low expenditure threshold for excluding a  
4 laboratory from the definition of applicable labora-  
5 tory under this paragraph, as the Secretary deter-  
6 mines appropriate.

7 “(3) APPLICABLE INFORMATION DEFINED.—

8 “(A) IN GENERAL.—In this section, sub-  
9 ject to subparagraph (B), the term ‘applicable  
10 information’ means, with respect to a labora-  
11 tory test for a data collection period, the fol-  
12 lowing:

13 “(i) The payment rate (as determined  
14 in accordance with paragraph (5)) that  
15 was paid by each private payor for the test  
16 during the period.

17 “(ii) The volume of such tests for  
18 each such payor for the period.

19 “(B) EXCEPTION FOR CERTAIN CONTRAC-  
20 TUAL ARRANGEMENTS.—Such term shall not  
21 include information with respect to a laboratory  
22 test for which payment is made on a capitated  
23 basis or other similar payment basis during the  
24 data collection period.

1           “(4) DATA COLLECTION PERIOD DEFINED.—In  
2 this section, the term ‘data collection period’ means  
3 a period of time, such as a previous 12 month pe-  
4 riod, specified by the Secretary.

5           “(5) TREATMENT OF DISCOUNTS.—The pay-  
6 ment rate reported by a laboratory under this sub-  
7 section shall reflect all discounts, rebates, coupons,  
8 and other price concessions, including those de-  
9 scribed in section 1847A(c)(3).

10          “(6) ENSURING COMPLETE REPORTING.—In  
11 the case where an applicable laboratory has more  
12 than one payment rate for the same payor for the  
13 same test or more than one payment rate for dif-  
14 ferent payors for the same test, the applicable lab-  
15 oratory shall report each such payment rate and the  
16 volume for the test at each such rate under this sub-  
17 section. Beginning with January 1, 2019, the Sec-  
18 retary may establish rules to aggregate reporting  
19 with respect to the situations described in the pre-  
20 ceding sentence.

21          “(7) CERTIFICATION.—An officer of the labora-  
22 tory shall certify the accuracy and completeness of  
23 the information reported under this subsection.

24          “(8) PRIVATE PAYOR DEFINED.—In this sec-  
25 tion, the term ‘private payor’ means the following:

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

4           “(B) A Medicare Advantage plan under  
5 part C.

6           “(C) A medicaid managed care organiza-  
7 tion (as defined in section 1903(m)).

8           “(9) CIVIL MONEY PENALTY.—

9           “(A) IN GENERAL.—If the Secretary deter-  
10 mines that an applicable laboratory has failed  
11 to report or made a misrepresentation or omis-  
12 sion in reporting information under this sub-  
13 section with respect to a clinical diagnostic lab-  
14 oratory test, the Secretary may apply a civil  
15 money penalty in an amount of up to \$10,000  
16 per day for each failure to report or each such  
17 misrepresentation or omission.

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

24           “(10) CONFIDENTIALITY OF INFORMATION.—  
25 Notwithstanding any other provision of law, infor-

1       mation disclosed by a laboratory under this sub-  
2       section is confidential and shall not be disclosed by  
3       the Secretary or a Medicare contractor in a form  
4       that discloses the identity of a specific payor or lab-  
5       oratory, or prices charged or payments made to any  
6       such laboratory, except—

7               “(A) as the Secretary determines to be  
8               necessary to carry out this section;

9               “(B) to permit the Comptroller General to  
10              review the information provided;

11              “(C) to permit the Director of the Con-  
12              gressional Budget Office to review the informa-  
13              tion provided; and

14              “(D) to permit the Medicare Payment Ad-  
15              visory Commission to review the information  
16              provided.

17              “(11) PROTECTION FROM PUBLIC DISCLO-  
18              SURE.—A payor shall not be identified on informa-  
19              tion reported under this subsection. The name of an  
20              applicable laboratory under this subsection shall be  
21              exempt from disclosure under section 552(b)(3) of  
22              title 5, United States Code.

23              “(12) REGULATIONS.—Not later than June 30,  
24              2015, the Secretary shall establish through notice

1 and comment rulemaking parameters for data collec-  
2 tion under this subsection.

3 “(b) PAYMENT FOR CLINICAL DIAGNOSTIC LABORA-  
4 TORY TESTS.—

5 “(1) USE OF PRIVATE PAYOR RATE INFORMA-  
6 TION TO DETERMINE MEDICARE PAYMENT RATES.—

7 “(A) IN GENERAL.—Subject to paragraph  
8 (3) and subsections (c) and (d), in the case of  
9 a clinical diagnostic laboratory test furnished on  
10 or after January 1, 2017, the payment amount  
11 under this section shall be equal to the weighted  
12 median determined for the test under para-  
13 graph (2) for the most recent data collection  
14 period.

15 “(B) APPLICATION OF PAYMENT AMOUNTS  
16 TO HOSPITAL LABORATORIES.—The payment  
17 amounts established under this section shall  
18 apply to a clinical diagnostic laboratory test  
19 furnished by a hospital laboratory if such test  
20 is paid for separately, and not as part of a bun-  
21 dled payment under section 1833(t).

22 “(2) CALCULATION OF WEIGHTED MEDIAN.—  
23 For each laboratory test with respect to which infor-  
24 mation is reported under subsection (a) for a data  
25 collection period, the Secretary shall calculate a



1 weighted median for the test for the period, by  
2 arraying the distribution of all payment rates re-  
3 ported for the period for each test weighted by vol-  
4 ume for each payor and each laboratory.

5 “(3) PHASE-IN OF REDUCTIONS FROM PRIVATE  
6 PAYOR RATE IMPLEMENTATION.—

7 “(A) IN GENERAL.—Payment amounts de-  
8 termined under this subsection for a clinical di-  
9 agnostic laboratory test for each of 2017  
10 through 2022 shall not result in a reduction in  
11 payments for a clinical diagnostic laboratory  
12 test for the year of greater than the applicable  
13 percent (as defined in subparagraph (B)) of the  
14 amount of payment for the test for the pre-  
15 ceding year.

16 “(B) APPLICABLE PERCENT DEFINED.—In  
17 this paragraph, the term ‘applicable percent’  
18 means—

19 “(i) for each of 2017 through 2019,  
20 10 percent; and

21 “(ii) for each of 2020 through 2022,  
22 15 percent.

23 “(C) NO APPLICATION TO NEW TESTS.—

24 This paragraph shall not apply to payment

1 amounts determined under this section for ei-  
2 ther of the following.

3 “(i) A new test under subsection (c).

4 “(ii) A new advanced diagnostic test  
5 (as defined in subsection (d)(5)) under  
6 subsection (d).

7 “(4) APPLICATION OF MARKET RATES.—

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

13 “(B) OTHER ADJUSTMENTS NOT APPLICA-  
14 BLE.—The payment amounts under this section  
15 shall not be subject to any adjustment (includ-  
16 ing any geographic adjustment, budget neu-  
17 trality adjustment, annual update, or other ad-  
18 justment).

19 “(5) SAMPLE COLLECTION FEE.—In the case of  
20 a sample collected from an individual in a skilled  
21 nursing facility or by a laboratory on behalf of a  
22 home health agency, the nominal fee that would oth-  
23 erwise apply under section 1833(h)(3)(A) shall be  
24 increased by \$2.

1       “(c) PAYMENT FOR NEW TESTS THAT ARE NOT AD-  
2 VANCED DIAGNOSTIC LABORATORY TESTS.—

3           “(1) PAYMENT DURING INITIAL PERIOD.—In  
4 the case of a clinical diagnostic laboratory test that  
5 is assigned a new or substantially revised HCPCS  
6 code on or after the date of enactment of this sec-  
7 tion, and which is not an advanced diagnostic lab-  
8 oratory test (as defined in subsection (d)(5)), during  
9 an initial period until payment rates under sub-  
10 section (b) are established for the test, payment for  
11 the test shall be determined—

12           “(A) using cross-walking (as described in  
13 section 414.508(a) of title 42, Code of Federal  
14 Regulations, or any successor regulation) to the  
15 most appropriate existing test under the fee  
16 schedule under this section during that period;  
17 or

18           “(B) if no existing test is comparable to  
19 the new test, according to the gapfilling process  
20 described in paragraph (2).

21           “(2) GAPFILLING PROCESS DESCRIBED.—The  
22 gapfilling process described in this paragraph shall  
23 take into account the following sources of informa-  
24 tion to determine gapfill amounts, if available:

1           “(A) Charges for the test and routine dis-  
2 counts to charges.

3           “(B) Resources required to perform the  
4 test.

5           “(C) Payment amounts determined by  
6 other payors.

7           “(D) Charges, payment amounts, and re-  
8 sources required for other tests that may be  
9 comparable or otherwise relevant.

10           “(E) Other criteria the Secretary deter-  
11 mines appropriate.

12           “(3) ADDITIONAL CONSIDERATION.—In deter-  
13 mining the payment amount under crosswalking or  
14 gapfilling processes under this subsection, the Sec-  
15 retary shall consider recommendations from the  
16 panel established under subsection (f)(1).

17           “(4) EXPLANATION OF PAYMENT RATES.—In  
18 the case of a clinical diagnostic laboratory test for  
19 which payment is made under this subsection, the  
20 Secretary shall make available to the public an ex-  
21 planation of the payment rate for the test, including  
22 an explanation of how the criteria described in para-  
23 graph (2) and paragraph (3) are applied.

24           “(d) PAYMENT FOR NEW ADVANCED DIAGNOSTIC  
25 LABORATORY TESTS.—

1           “(1) PAYMENT DURING INITIAL PERIOD.—

2                   “(A) IN GENERAL.—In the case of an ad-  
3           vanced diagnostic laboratory test for which pay-  
4           ment has not been made under the fee schedule  
5           under section 1833(h) prior to the date of en-  
6           actment of this section, during an initial period  
7           of three quarters, the payment amount for the  
8           test for such period shall be based on the actual  
9           list charge for the laboratory test.

10                   “(B) ACTUAL LIST CHARGE.—For pur-  
11           poses of subparagraph (A), the term ‘actual list  
12           charge’, with respect to a laboratory test fur-  
13           nished during such period, means the publicly  
14           available rate on the first day at which the test  
15           is available for purchase by a private payor.

16                   “(2) SPECIAL RULE FOR TIMING OF INITIAL  
17           REPORTING.—With respect to an advanced diag-  
18           nostic laboratory test described in paragraph (1)(A),  
19           an applicable laboratory shall initially be required to  
20           report under subsection (a) not later than the last  
21           day of the second quarter of the initial period under  
22           such paragraph.

23                   “(3) APPLICATION OF MARKET RATES AFTER  
24           INITIAL PERIOD.—Subject to paragraph (4), data re-  
25           ported under paragraph (2) shall be used to estab-

1       lish the payment amount for an advanced diagnostic  
2       laboratory test after the initial period under para-  
3       graph (1)(A) using the methodology described in  
4       subsection (b). Such payment amount shall continue  
5       to apply until the year following the next data collec-  
6       tion period.

7               “(4) RECOUPMENT IF ACTUAL LIST CHARGE  
8       EXCEEDS MARKET RATE.—With respect to the initial  
9       period described in paragraph (1)(A), if, after such  
10      period, the Secretary determines that the payment  
11      amount for an advanced diagnostic laboratory test  
12      under paragraph (1)(A) that was applicable during  
13      the period was greater than 130 percent of the pay-  
14      ment amount for the test established using the  
15      methodology described in subsection (b) that is ap-  
16      plicable after such period, the Secretary shall recoup  
17      the difference between such payment amounts for  
18      tests furnished during such period.

19              “(5) ADVANCED DIAGNOSTIC LABORATORY  
20      TEST DEFINED.—In this subsection, the term ‘ad-  
21      vanced diagnostic laboratory test’ means a clinical  
22      diagnostic laboratory test covered under this part  
23      that is offered and furnished only by a single labora-  
24      tory and not sold for use by a laboratory other than

1 the original developing laboratory (or a successor  
2 owner) and meets one of the following criteria:

3 “(A) The test is an analysis of multiple  
4 biomarkers of DNA, RNA, or proteins com-  
5 bined with a unique algorithm to yield a single  
6 patient-specific result.

7 “(B) The test is cleared or approved by the  
8 Food and Drug Administration.

9 “(C) The test meets other similar criteria  
10 established by the Secretary.

11 “(e) CODING.—

12 “(1) TEMPORARY CODES FOR CERTAIN NEW  
13 TESTS.—

14 “(A) IN GENERAL.—The Secretary shall  
15 adopt temporary HCPCS codes to identify new  
16 advanced diagnostic laboratory tests (as defined  
17 in subsection (d)(5)) and new laboratory tests  
18 that are cleared or approved by the Food and  
19 Drug Administration.

20 “(B) DURATION.—

21 “(i) IN GENERAL.—Subject to clause  
22 (ii), the temporary code shall be effective  
23 until a permanent HCPCS code is estab-  
24 lished (but not to exceed 2 years).

1                   “(ii) EXCEPTION.—The Secretary  
2                   may extend the temporary code or estab-  
3                   lish a permanent HCPCS code, as the Sec-  
4                   retary determines appropriate.

5                   “(2) EXISTING TESTS.—Not later than January  
6                   1, 2016, for each existing advanced diagnostic lab-  
7                   oratory test (as so defined) and each existing clinical  
8                   diagnostic laboratory test that is cleared or approved  
9                   by the Food and Drug Administration for which  
10                  payment is made under this part as of the date of  
11                  enactment of this section, if such test has not al-  
12                  ready been assigned a unique HCPCS code, the Sec-  
13                  retary shall—

14                  “(A) assign a unique HCPCS code for the  
15                  test; and

16                  “(B) publicly report the payment rate for  
17                  the test.

18                  “(3) ESTABLISHMENT OF UNIQUE IDENTIFIER  
19                  FOR CERTAIN TESTS.—For purposes of tracking and  
20                  monitoring, if a laboratory or a manufacturer re-  
21                  quests a unique identifier for an advanced diagnostic  
22                  laboratory test (as so defined) or a laboratory test  
23                  that is cleared or approved by the Food and Drug  
24                  Administration, the Secretary shall utilize a means



1 to uniquely track such test through a mechanism  
2 such as a HCPCS code or modifier.

3 “(f) INPUT FROM CLINICIANS AND TECHNICAL EX-  
4 PERTS.—

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

15 “(A) input on—

16 “(i) the establishment of payment  
17 rates under this section for new clinical di-  
18 agnostic laboratory tests, including wheth-  
19 er to use crosswalking or gapfilling proc-  
20 esses to determine payment for a specific  
21 new test; and

22 “(ii) the factors used in determining  
23 coverage and payment processes for new  
24 clinical diagnostic laboratory tests; and

1           “(B) recommendations to the Secretary  
2           under this section.

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

6           “(3) CONTINUATION OF ANNUAL MEETING.—  
7           The Secretary shall continue to convene the annual  
8           meeting described in section 1833(h)(8)(B)(iii) after  
9           the implementation of this section for purposes of  
10          receiving comments and recommendations (and data  
11          on which the recommendations are based) as de-  
12          scribed in such section on the establishment of pay-  
13          ment amounts under this section.

14          “(g) COVERAGE.—

15                 “(1) ISSUANCE OF COVERAGE POLICIES.—

16                         “(A) IN GENERAL.—A medicare adminis-  
17                         trative contractor shall only issue a coverage  
18                         policy with respect to a clinical diagnostic lab-  
19                         oratory test in accordance with the process for  
20                         making a local coverage determination (as de-  
21                         fined in section 1869(f)(2)(B)), including the  
22                         appeals and review process for local coverage  
23                         determinations under part 426 of title 42, Code  
24                         of Federal Regulations (or successor regula-  
25                         tions).

1           “(B) NO EFFECT ON NATIONAL COVERAGE  
2           DETERMINATION PROCESS.—This paragraph  
3           shall not apply to the national coverage deter-  
4           mination process (as defined in section  
5           1869(f)(1)(B)).

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

9           “(2) DESIGNATION OF ONE OR MORE MEDICARE  
10          ADMINISTRATIVE CONTRACTORS FOR CLINICAL DIAG-  
11          NOSTIC LABORATORY TESTS.—The Secretary may  
12          designate one or more (not to exceed 4) medicare  
13          administrative contractors to either establish cov-  
14          erage policies or establish coverage policies and proc-  
15          ess claims for payment for clinical diagnostic labora-  
16          tory tests, as determined appropriate by the Sec-  
17          retary.

18          “(h) IMPLEMENTATION.—

19                 “(1) IMPLEMENTATION.—There shall be no ad-  
20                 ministrative or judicial review under section 1869,  
21                 section 1878, or otherwise, of the establishment of  
22                 payment amounts under this section.

23                 “(2) ADMINISTRATION.—Chapter 35 of title 44,  
24                 United States Code, shall not apply to information  
25                 collected under this section.

1           “(3) FUNDING.—For purposes of implementing  
2           this section, the Secretary shall provide for the  
3           transfer, from the Federal Supplementary Medical  
4           Insurance Trust Fund under section 1841, to the  
5           Centers for Medicare & Medicaid Services Program  
6           Management Account, for each of fiscal years 2014  
7           through 2018, \$4,000,000, and for each of fiscal  
8           years 2019 through 2023, \$3,000,000. Amounts  
9           transferred under the preceding sentence shall re-  
10          main available until expended.

11          “(i) TRANSITIONAL RULE.—During the period begin-  
12          ning on the date of enactment of this section and ending  
13          on December 31, 2016, with respect to advanced diag-  
14          nostic laboratory tests under this part, the Secretary shall  
15          use the methodologies for pricing, coding, and coverage  
16          in effect on the day before such date of enactment, which  
17          may include cross-walking or gapfilling methods.”.

18          (b) CONFORMING AMENDMENTS.—

19                 (1) Section 1833(a) of the Social Security Act  
20                 (42 U.S.C. 1395l(a)) is amended—

21                         (A) in paragraph (1)(D)—

22                                 (i) by striking “(i) on the basis” and  
23                                 inserting “(i)(I) on the basis”;

24                                 (ii) in subclause (I), as added by  
25                                 clause (i), by striking “subsection (h)(1)”

1 and inserting “subsection (h)(1) (for tests  
2 furnished before January 1, 2017)”;

3 (iii) by striking “or (ii)” and inserting  
4 “or (II) under section 1834A (for tests  
5 furnished on or after January 1, 2017),  
6 the amount paid shall be equal to 80 per-  
7 cent (or 100 percent, in the case of such  
8 tests for which payment is made on an as-  
9 signment-related basis) of the lesser of the  
10 amount determined under such section or  
11 the amount of the charges billed for the  
12 tests, or (ii)”;

13 (iv) in clause (ii), by striking “on the  
14 basis” and inserting “for tests furnished  
15 before January 1, 2017, on the basis”;

16 (B) in paragraph (2)(D)—

17 (i) by striking “(i) on the basis” and  
18 inserting “(i)(I) on the basis”;

19 (ii) in subclause (I), as added by  
20 clause (i), by striking “subsection (h)(1)”  
21 and inserting “subsection (h)(1) (for tests  
22 furnished before January 1, 2017)”;

23 (iii) by striking “or (ii)” and inserting  
24 “or (II) under section 1834A (for tests  
25 furnished on or after January 1, 2017),

1 the amount paid shall be equal to 80 per-  
2 cent (or 100 percent, in the case of such  
3 tests for which payment is made on an as-  
4 signment-related basis or to a provider  
5 having an agreement under section 1866)  
6 of the lesser of the amount determined  
7 under such section or the amount of the  
8 charges billed for the tests, or (ii)”; and

9 (iv) in clause (ii), by striking “on the  
10 basis” and inserting “for tests furnished  
11 before January 1, 2017, on the basis”;

12 (C) in subsection (b)(3)(B), by striking  
13 “on the basis” and inserting “for tests fur-  
14 nished before January 1, 2017, on the basis”;

15 (D) in subsection (h)(2)(A)(i), by striking  
16 “and subject to” and inserting “and, for tests  
17 furnished before the date of enactment of sec-  
18 tion 1834A, subject to”;

19 (E) in subsection (h)(3), in the matter pre-  
20 ceeding subparagraph (A), by striking “fee  
21 schedules” and inserting “fee schedules (for  
22 tests furnished before January 1, 2017) or  
23 under section 1834A (for tests furnished on or  
24 after January 1, 2017), subject to subsection  
25 (b)(5) of such section”;

1 (F) in subsection (h)(6), by striking “In  
2 the case” and inserting “For tests furnished be-  
3 fore January 1, 2017, in the case”; and

4 (G) in subsection (h)(7), in the first sen-  
5 tence—

6 (i) by striking “and (4)” and inserting  
7 “and (4) and section 1834A”; and

8 (ii) by striking “under this sub-  
9 section” and inserting “under this part”.

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

13 “(C) LOCAL COVERAGE DETERMINATIONS  
14 FOR CLINICAL DIAGNOSTIC LABORATORY  
15 TESTS.—For provisions relating to local cov-  
16 erage determinations for clinical diagnostic lab-  
17 oratory tests, see section 1834A(g).”.

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

21 (1) GAO STUDY AND REPORT ON IMPLEMENTA-  
22 TION OF NEW PAYMENT RATES FOR CLINICAL DIAG-  
23 NOSTIC LABORATORY TESTS.—

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

1 as the “Comptroller General”) shall conduct a  
2 study on the implementation of section 1834A  
3 of the Social Security Act, as added by sub-  
4 section (a). The study shall include an analysis  
5 of—

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

9 (I) how such payment rates com-  
10 pare across settings;

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

13 (III) trends by private payors to  
14 move to alternative payment meth-  
15 odologies for laboratory tests;

16 (ii) the conversion to the new payment  
17 rate for laboratory tests under such sec-  
18 tion;

19 (iii) the impact of such implementa-  
20 tion on beneficiary access under title  
21 XVIII of the Social Security Act;

22 (iv) the impact of the new payment  
23 system on laboratories that furnish a low  
24 volume of services and laboratories that  
25 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

1 House of Representatives and the Committee  
2 on Finance of the Senate a report on the study  
3 under subparagraph (A), including rec-  
4 ommendations for such legislation and adminis-  
5 trative action as the Comptroller General deter-  
6 mines appropriate.

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

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

16 (B) conduct analyses the Inspector General  
17 determines appropriate with respect to the im-  
18 plementation and effect of the new payment  
19 system for laboratory tests under section 1834A  
20 of the Social Security Act, as added by sub-  
21 section (a).

1 **SEC. 217. REVISIONS UNDER THE MEDICARE ESRD PRO-**  
2 **SPECTIVE PAYMENT SYSTEM.**

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

6 (1) by striking “2016” and inserting “2024”;

7 and

8 (2) by adding at the end the following new sen-  
9 tence: “Notwithstanding section 1881(b)(14)(A)(ii)  
10 of the Social Security Act (42 U.S.C.  
11 1395rr(b)(14)(A)(ii)), implementation of the policy  
12 described in the previous sentence shall be based on  
13 data from the most recent year available.”.

14 (b) MITIGATION OF THE APPLICATION OF ADJUST-  
15 MENT TO ESRD BUNDLED PAYMENT RATE TO ACCOUNT  
16 FOR CHANGES IN THE UTILIZATION OF CERTAIN DRUGS  
17 AND BIOLOGICALS.—

18 (1) IN GENERAL.—Section 1881(b)(14)(I) of  
19 the Social Security Act (42 U.S.C. 1395rr(b)(14)(I))  
20 is amended by inserting “and before January 1,  
21 2015,” after “January 1, 2014,”.

22 (2) MARKET BASKET.—Section  
23 1881(b)(14)(F)(i) of the Social Security Act (42  
24 U.S.C. 1395rr(b)(14)(F)(i)) is amended—

25 (A) in subclause (I)—

1 (i) by striking “subclause (II)” and  
2 inserting “subclauses (II) and (III)”; and

3 (ii) by adding at the end the following  
4 new sentence: “In order to accomplish the  
5 purposes of subparagraph (I) with respect  
6 to 2016, 2017, and 2018, after deter-  
7 mining the increase factor described in the  
8 preceding sentence for each of 2016, 2017,  
9 and 2018, the Secretary shall reduce such  
10 increase factor by 1.25 percentage points  
11 for each of 2016 and 2017 and by 1 per-  
12 centage point for 2018.”;

13 (B) in subclause (II), by striking “For  
14 2012” and inserting “Subject to subclause  
15 (III), for 2012”; and

16 (C) by adding at the end the following new  
17 subclause:

18 “(III) Notwithstanding subclauses (I) and (II),  
19 in order to accomplish the purposes of subparagraph  
20 (I) with respect to 2015, the increase factor de-  
21 scribed in subclause (I) for 2015 shall be 0.0 percent  
22 pursuant to the regulation issued by the Secretary  
23 on December 2, 2013, entitled ‘Medicare Program;  
24 End-Stage Renal Disease Prospective Payment Sys-  
25 tem, Quality Incentive Program, and Durable Med-

1 ical Equipment, Prosthetics, Orthotics, and Supplies;  
2 Final Rule’ (78 Fed. Reg. 72156).”.

3 (c) DRUG DESIGNATIONS.—As part of the promulga-  
4 tion of annual rule for the Medicare end stage renal dis-  
5 ease prospective payment system under section  
6 1881(b)(14) of the Social Security Act (42 U.S.C.  
7 1395rr(b)(14)) for calendar year 2016, the Secretary of  
8 Health and Human Services (in this subsection referred  
9 to as the “Secretary”) shall establish a process for—

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

12 (2) including new injectable and intravenous  
13 products into the bundled payment under such sys-  
14 tem.

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

20 (1) in subparagraph (A)—

21 (A) in clause (ii), by striking “and” at the  
22 end;

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

1 (C) by inserting after clause (ii) the fol-  
2 lowing new clause:

3 “(iii) for 2016 and subsequent years,  
4 measures described in subparagraph  
5 (E)(i); and”;

6 (2) in subparagraph (B)(i), by striking  
7 “(A)(iii)” and inserting “(A)(iv)”; and

8 (3) by adding at the end the following new sub-  
9 paragraph:

10 “(E) MEASURES SPECIFIC TO THE CONDI-  
11 TIONS TREATED WITH ORAL-ONLY DRUGS.—

12 “(i) IN GENERAL.—The measures de-  
13 scribed in this subparagraph are measures  
14 specified by the Secretary that are specific  
15 to the conditions treated with oral-only  
16 drugs. To the extent feasible, such meas-  
17 ures shall be outcomes-based measures.

18 “(ii) CONSULTATION.—In specifying  
19 the measures under clause (i), the Sec-  
20 retary shall consult with interested stake-  
21 holders.

22 “(iii) USE OF ENDORSED MEAS-  
23 URES.—

24 “(I) IN GENERAL.—Subject to  
25 subclause (I), any measures specified

1 under clause (i) must have been en-  
2 dored by the entity with a contract  
3 under section 1890(a).

4 “(II) EXCEPTION.—If the entity  
5 with a contract under section 1890(a)  
6 has not endorsed a measure for a  
7 specified area or topic related to  
8 measures described in clause (i) that  
9 the Secretary determines appropriate,  
10 the Secretary may specify a measure  
11 that is endorsed or adopted by a con-  
12 sensus organization recognized by the  
13 Secretary that has expertise in clinical  
14 guidelines for kidney disease.”.

15 (e) AUDITS OF COST REPORTS OF ESRD PROVIDERS

16 AS RECOMMENDED BY MEDPAC.—

17 (1) IN GENERAL.—The Secretary of Health and  
18 Human Services shall conduct audits of Medicare  
19 cost reports beginning during 2012 for a representa-  
20 tive sample of providers of services and renal dialysis  
21 facilities furnishing renal dialysis services.

22 (2) FUNDING.—For purposes of carrying out  
23 paragraph (1), the Secretary of Health and Human  
24 Services shall provide for the transfer from the Fed-  
25 eral Supplementary Medical Insurance Trust Fund

1 established under section 1841 of the Social Security  
2 Act (42 U.S.C. 1395t) to the Centers for Medicare  
3 & Medicaid Services Program Management Account  
4 of \$18,000,000 for fiscal year 2014. Amounts trans-  
5 ferred under this paragraph for a fiscal year shall be  
6 available until expended.

7 **SEC. 218. QUALITY INCENTIVES FOR COMPUTED TOMOG-**  
8 **RAPHY DIAGNOSTIC IMAGING AND PRO-**  
9 **MOTING EVIDENCE-BASED CARE.**

10 (a) QUALITY INCENTIVES TO PROMOTE PATIENT  
11 SAFETY AND PUBLIC HEALTH IN COMPUTED TOMOG-  
12 RAPHY DIAGNOSTIC IMAGING.—

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

16 “(p) QUALITY INCENTIVES TO PROMOTE PATIENT  
17 SAFETY AND PUBLIC HEALTH IN COMPUTED TOMOG-  
18 RAPHY.—

19 “(1) QUALITY INCENTIVES.—In the case of an  
20 applicable computed tomography service (as defined  
21 in paragraph (2)) for which payment is made under  
22 an applicable payment system (as defined in para-  
23 graph (3)) and that is furnished on or after January  
24 1, 2016, using equipment that is not consistent with  
25 the CT equipment standard (described in paragraph



1 (4)), the payment amount for such service shall be  
2 reduced by the applicable percentage (as defined in  
3 paragraph (5)).

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

13 “(3) APPLICABLE PAYMENT SYSTEM DE-  
14 FINED.—In this subsection, the term ‘applicable  
15 payment system’ means the following:

16 “(A) The technical component and the  
17 technical component of the global fee under the  
18 fee schedule established under section 1848(b).

19 “(B) The prospective payment system for  
20 hospital outpatient department services under  
21 section 1833(t).

22 “(4) CONSISTENCY WITH CT EQUIPMENT  
23 STANDARD.—In this subsection, the term ‘not con-  
24 sistent with the CT equipment standard’ means,  
25 with respect to an applicable computed tomography

1 service, that the service was furnished using equip-  
2 ment that does not meet each of the attributes of  
3 the National Electrical Manufacturers Association  
4 (NEMA) Standard XR–29–2013, entitled ‘Standard  
5 Attributes on CT Equipment Related to Dose Opti-  
6 mization and Management’. Through rulemaking,  
7 the Secretary may apply successor standards.

8 “(5) APPLICABLE PERCENTAGE DEFINED.—In  
9 this subsection, the term ‘applicable percentage’  
10 means—

11 “(A) for 2016, 5 percent; and

12 “(B) for 2017 and subsequent years, 15  
13 percent.

14 “(6) IMPLEMENTATION.—

15 “(A) INFORMATION.—The Secretary shall  
16 require that information be provided and at-  
17 tested to by a supplier and a hospital outpatient  
18 department that indicates whether an applicable  
19 computed tomography service was furnished  
20 that was not consistent with the CT equipment  
21 standard (described in paragraph (4)). Such in-  
22 formation may be included on a claim and may  
23 be a modifier. Such information shall be  
24 verified, as appropriate, as part of the periodic

1 accreditation of suppliers under section 1834(e)  
2 and hospitals under section 1865(a).

3 “(B) ADMINISTRATION.—Chapter 35 of  
4 title 44, United States Code, shall not apply to  
5 information described in subparagraph (A).”.

6 (2) CONFORMING AMENDMENTS.—

7 (A) PROSPECTIVE PAYMENT SYSTEM FOR  
8 HOSPITAL OUTPATIENT DEPARTMENT SERV-  
9 ICES.—Section 1833(t) of the Social Security  
10 Act (42 13951(t)) is amended by adding at the  
11 end the following new paragraph:

12 “(20) NOT BUDGET NEUTRAL APPLICATION OF  
13 REDUCED EXPENDITURES RESULTING FROM QUAL-  
14 ITY INCENTIVES FOR COMPUTED TOMOGRAPHY.—  
15 The Secretary shall not take into account the re-  
16 duced expenditures that result from the application  
17 of section 1834(p) in making any budget neutrality  
18 adjustments this subsection.”.

19 (B) PHYSICIAN FEE SCHEDULE.—Section  
20 1848(c)(2)(B)(v) of the Social Security Act (42  
21 U.S.C. 1395w-4(c)(2)(B)(v)) is amended by  
22 adding at the end the following new subclause:

23 “(VIII) REDUCED EXPENDI-  
24 TURES ATTRIBUTABLE TO APPLICA-  
25 TION OF QUALITY INCENTIVES FOR

1                   COMPUTED TOMOGRAPHY.—Effective  
2                   for fee schedules established beginning  
3                   with 2016, reduced expenditures at-  
4                   tributable to the application of the  
5                   quality incentives for computed to-  
6                   mography under section 1834(p)”.

7           (b) PROMOTING EVIDENCE-BASED CARE.—

8                   (1) IN GENERAL.—Section 1834 of the Social  
9                   Security Act (42 U.S.C. 1395m), as amended by  
10                  subsection (a), is amended by adding at the end the  
11                  following new subsection:

12                  “(q) RECOGNIZING APPROPRIATE USE CRITERIA FOR  
13                  CERTAIN IMAGING SERVICES.—

14                          “(1) PROGRAM ESTABLISHED.—

15                                  “(A) IN GENERAL.—The Secretary shall  
16                                  establish a program to promote the use of ap-  
17                                  propriate use criteria (as defined in subpara-  
18                                  graph (B)) for applicable imaging services (as  
19                                  defined in subparagraph (C)) furnished in an  
20                                  applicable setting (as defined in subparagraph  
21                                  (D)) by ordering professionals and furnishing  
22                                  professionals (as defined in subparagraphs (E)  
23                                  and (F), respectively).

24                                  “(B) APPROPRIATE USE CRITERIA DE-  
25                                  FINED.—In this subsection, the term ‘appro-

1           appropriate use criteria’ means criteria, only devel-  
2           oped or endorsed by national professional med-  
3           ical specialty societies or other provider-led enti-  
4           ties, to assist ordering professionals and fur-  
5           nishing professionals in making the most appro-  
6           priate treatment decision for a specific clinical  
7           condition for an individual. To the extent fea-  
8           sible, such criteria shall be evidence-based.

9           “(C) APPLICABLE IMAGING SERVICE DE-  
10          FINED.—In this subsection, the term ‘applicable  
11          imaging service’ means an advanced diagnostic  
12          imaging service (as defined in subsection  
13          (e)(1)(B)) for which the Secretary determines—

14                 “(i) one or more applicable appro-  
15                 priate use criteria specified under para-  
16                 graph (2) apply;

17                 “(ii) there are one or more qualified  
18                 clinical decision support mechanisms listed  
19                 under paragraph (3)(C); and

20                 “(iii) one or more of such mechanisms  
21                 is available free of charge.

22          “(D) APPLICABLE SETTING DEFINED.—In  
23          this subsection, the term ‘applicable setting’  
24          means a physician’s office, a hospital outpatient  
25          department (including an emergency depart-

1           ment), an ambulatory surgical center, and any  
2           other provider-led outpatient setting determined  
3           appropriate by the Secretary.

4           “(E) ORDERING PROFESSIONAL DE-  
5           FINED.—In this subsection, the term ‘ordering  
6           professional’ means a physician (as defined in  
7           section 1861(r)) or a practitioner described in  
8           section 1842(b)(18)(C) who orders an applica-  
9           ble imaging service.

10          “(F) FURNISHING PROFESSIONAL DE-  
11          FINED.—In this subsection, the term ‘fur-  
12          nishing professional’ means a physician (as de-  
13          fined in section 1861(r)) or a practitioner de-  
14          scribed in section 1842(b)(18)(C) who furnishes  
15          an applicable imaging service.

16          “(2) ESTABLISHMENT OF APPLICABLE APPRO-  
17          PRIATE USE CRITERIA.—

18          “(A) IN GENERAL.—Not later than No-  
19          vember 15, 2015, the Secretary shall through  
20          rulemaking, and in consultation with physi-  
21          cians, practitioners, and other stakeholders,  
22          specify applicable appropriate use criteria for  
23          applicable imaging services only from among  
24          appropriate use criteria developed or endorsed

1 by national professional medical specialty soci-  
2 eties or other provider-led entities.

3 “(B) CONSIDERATIONS.—In specifying ap-  
4 plicable appropriate use criteria under subpara-  
5 graph (A), the Secretary shall take into account  
6 whether the criteria—

7 “(i) have stakeholder consensus;

8 “(ii) are scientifically valid and evi-  
9 dence based; and

10 “(iii) are based on studies that are  
11 published and reviewable by stakeholders.

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

19 “(D) TREATMENT OF MULTIPLE APPLICA-  
20 BLE APPROPRIATE USE CRITERIA.—In the case  
21 where the Secretary determines that more than  
22 one appropriate use criterion applies with re-  
23 spect to an applicable imaging service, the Sec-  
24 retary shall apply one or more applicable appro-

1           pripate use criteria under this paragraph for the  
2           service.

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

5                   “(A) IDENTIFICATION OF MECHANISMS TO  
6           CONSULT WITH APPLICABLE APPROPRIATE USE  
7           CRITERIA.—

8                           “(i) IN GENERAL.—The Secretary  
9                           shall specify qualified clinical decision sup-  
10                           port mechanisms that could be used by or-  
11                           dering professionals to consult with appli-  
12                           cable appropriate use criteria for applicable  
13                           imaging services.

14                           “(ii) CONSULTATION.—The Secretary  
15                           shall consult with physicians, practitioners,  
16                           health care technology experts, and other  
17                           stakeholders in specifying mechanisms  
18                           under this paragraph.

19                           “(iii) INCLUSION OF CERTAIN MECHA-  
20                           NISMS.—Mechanisms specified under this  
21                           paragraph may include any or all of the  
22                           following that meet the requirements de-  
23                           scribed in subparagraph (B)(ii):

24                                   “(I) Use of clinical decision sup-  
25                                   port modules in certified EHR tech-



1 nology (as defined in section  
2 1848(o)(4)).

3 “(II) Use of private sector clin-  
4 ical decision support mechanisms that  
5 are independent from certified EHR  
6 technology, which may include use of  
7 clinical decision support mechanisms  
8 available from medical specialty orga-  
9 nizations.

10 “(III) Use of a clinical decision  
11 support mechanism established by the  
12 Secretary.

13 “(B) QUALIFIED CLINICAL DECISION SUP-  
14 PORT MECHANISMS.—

15 “(i) IN GENERAL.—For purposes of  
16 this subsection, a qualified clinical decision  
17 support mechanism is a mechanism that  
18 the Secretary determines meets the re-  
19 quirements described in clause (ii).

20 “(ii) REQUIREMENTS.—The require-  
21 ments described in this clause are the fol-  
22 lowing:

23 “(I) The mechanism makes avail-  
24 able to the ordering professional appli-  
25 cable appropriate use criteria specified

1 under paragraph (2) and the sup-  
2 porting documentation for the applica-  
3 ble imaging service ordered.

4 “(II) In the case where there is  
5 more than one applicable appropriate  
6 use criterion specified under such  
7 paragraph for an applicable imaging  
8 service, the mechanism indicates the  
9 criteria that it uses for the service.

10 “(III) The mechanism determines  
11 the extent to which an applicable im-  
12 aging service ordered is consistent  
13 with the applicable appropriate use  
14 criteria so specified.

15 “(IV) The mechanism generates  
16 and provides to the ordering profes-  
17 sional a certification or documentation  
18 that documents that the qualified clin-  
19 ical decision support mechanism was  
20 consulted by the ordering professional.

21 “(V) The mechanism is updated  
22 on a timely basis to reflect revisions  
23 to the specification of applicable ap-  
24 propriate use criteria under such  
25 paragraph.

1                   “(VI) The mechanism meets pri-  
2                   vacy and security standards under ap-  
3                   plicable provisions of law.

4                   “(VII) The mechanism performs  
5                   such other functions as specified by  
6                   the Secretary, which may include a re-  
7                   quirement to provide aggregate feed-  
8                   back to the ordering professional.

9                   “(C) LIST OF MECHANISMS FOR CON-  
10                  SULTATION WITH APPLICABLE APPROPRIATE  
11                  USE CRITERIA.—

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

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

21                  “(4) CONSULTATION WITH APPLICABLE APPRO-  
22                  PRIATE USE CRITERIA.—

23                  “(A) CONSULTATION BY ORDERING PRO-  
24                  FESSIONAL.—Beginning with January 1, 2017,  
25                  subject to subparagraph (C), with respect to an

1 applicable imaging service ordered by an order-  
2 ing professional that would be furnished in an  
3 applicable setting and paid for under an appli-  
4 cable payment system (as defined in subpara-  
5 graph (D)), an ordering professional shall—

6 “(i) consult with a qualified decision  
7 support mechanism listed under paragraph  
8 (3)(C); and

9 “(ii) provide to the furnishing profes-  
10 sional the information described in clauses  
11 (i) through (iii) of subparagraph (B).

12 “(B) REPORTING BY FURNISHING PROFES-  
13 SIONAL.—Beginning with January 1, 2017,  
14 subject to subparagraph (C), with respect to an  
15 applicable imaging service furnished in an ap-  
16 plicable setting and paid for under an applica-  
17 ble payment system (as defined in subpara-  
18 graph (D)), payment for such service may only  
19 be made if the claim for the service includes the  
20 following:

21 “(i) Information about which qualified  
22 clinical decision support mechanism was  
23 consulted by the ordering professional for  
24 the service.

25 “(ii) Information regarding—

1           “(I) whether the service ordered  
2           would adhere to the applicable appro-  
3           priate use criteria specified under  
4           paragraph (2);

5           “(II) whether the service ordered  
6           would not adhere to such criteria; or

7           “(III) whether such criteria was  
8           not applicable to the service ordered.

9           “(iii) The national provider identifier  
10          of the ordering professional (if different  
11          from the furnishing professional).

12          “(C) EXCEPTIONS.—The provisions of sub-  
13          paragraphs (A) and (B) and paragraph (6)(A)  
14          shall not apply to the following:

15               “(i) EMERGENCY SERVICES.—An ap-  
16               plicable imaging service ordered for an in-  
17               dividual with an emergency medical condi-  
18               tion (as defined in section 1867(e)(1)).

19               “(ii) INPATIENT SERVICES.—An appli-  
20               cable imaging service ordered for an inpa-  
21               tient and for which payment is made under  
22               part A.

23               “(iii) SIGNIFICANT HARDSHIP.—An  
24               applicable imaging service ordered by an  
25               ordering professional who the Secretary

1           may, on a case-by-case basis, exempt from  
2           the application of such provisions if the  
3           Secretary determines, subject to annual re-  
4           newal, that consultation with applicable ap-  
5           propriate use criteria would result in a sig-  
6           nificant hardship, such as in the case of a  
7           professional who practices in a rural area  
8           without sufficient Internet access.

9           “(D) APPLICABLE PAYMENT SYSTEM DE-  
10          FINED.—In this subsection, the term ‘applicable  
11          payment system’ means the following:

12                   “(i) The physician fee schedule estab-  
13                   lished under section 1848(b).

14                   “(ii) The prospective payment system  
15                   for hospital outpatient department services  
16                   under section 1833(t).

17                   “(iii) The ambulatory surgical center  
18                   payment systems under section 1833(i).

19          “(5) IDENTIFICATION OF OUTLIER ORDERING  
20          PROFESSIONALS.—

21                   “(A) IN GENERAL.—With respect to appli-  
22                   cable imaging services furnished beginning with  
23                   2017, the Secretary shall determine, on an an-  
24                   nual basis, no more than five percent of the

1 total number of ordering professionals who are  
2 outlier ordering professionals.

3 “(B) OUTLIER ORDERING PROFES-  
4 SIONALS.—The determination of an outlier or-  
5 dering professional shall—

6 “(i) be based on low adherence to ap-  
7 plicable appropriate use criteria specified  
8 under paragraph (2), which may be based  
9 on comparison to other ordering profes-  
10 sionals; and

11 “(ii) include data for ordering profes-  
12 sionals for whom prior authorization under  
13 paragraph (6)(A) applies.

14 “(C) USE OF TWO YEARS OF DATA.—The  
15 Secretary shall use two years of data to identify  
16 outlier ordering professionals under this para-  
17 graph.

18 “(D) PROCESS.—The Secretary shall es-  
19 tablish a process for determining when an  
20 outlier ordering professional is no longer an  
21 outlier ordering professional.

22 “(E) CONSULTATION WITH STAKE-  
23 HOLDERS.—The Secretary shall consult with  
24 physicians, practitioners and other stakeholders

1 in developing methods to identify outlier order-  
2 ing professionals under this paragraph.

3 “(6) PRIOR AUTHORIZATION FOR ORDERING  
4 PROFESSIONALS WHO ARE OUTLIERS.—

5 “(A) IN GENERAL.—Beginning January 1,  
6 2020, subject to paragraph (4)(C), with respect  
7 to services furnished during a year, the Sec-  
8 retary shall, for a period determined appro-  
9 priate by the Secretary, apply prior authoriza-  
10 tion for applicable imaging services that are or-  
11 dered by an outlier ordering professional identi-  
12 fied under paragraph (5).

13 “(B) APPROPRIATE USE CRITERIA IN  
14 PRIOR AUTHORIZATION.—In applying prior au-  
15 thorization under subparagraph (A), the Sec-  
16 retary shall utilize only the applicable appro-  
17 priate use criteria specified under this sub-  
18 section.

19 “(C) FUNDING.—For purposes of carrying  
20 out this paragraph, the Secretary shall provide  
21 for the transfer, from the Federal Supple-  
22 mentary Medical Insurance Trust Fund under  
23 section 1841, of \$5,000,000 to the Centers for  
24 Medicare & Medicaid Services Program Man-  
25 agement Account for each of fiscal years 2019



1 through 2021. Amounts transferred under the  
2 preceding sentence shall remain available until  
3 expended.

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

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

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

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

1 Act (42 U.S.C. 1395j et seq.), such as radiation  
2 therapy and clinical diagnostic laboratory services.

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

5 Section 1898(b)(1) of the Social Security Act (42  
6 U.S.C. 1395iii(b)(1)) is amended by striking  
7 “\$2,300,000,000” and inserting “\$0”.

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

10 (a) **AUTHORITY TO COLLECT AND USE INFORMA-**  
11 **TION ON PHYSICIANS’ SERVICES IN THE DETERMINATION**  
12 **OF RELATIVE VALUES.—**

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

17 “(M) **AUTHORITY TO COLLECT AND USE**  
18 **INFORMATION ON PHYSICIANS’ SERVICES IN**  
19 **THE DETERMINATION OF RELATIVE VALUES.—**

20 “(i) **COLLECTION OF INFORMATION.—**

21 Notwithstanding any other provision of  
22 law, the Secretary may collect or obtain in-  
23 formation on the resources directly or indi-  
24 rectly related to furnishing services for  
25 which payment is made under the fee

1 schedule established under subsection (b).  
2 Such information may be collected or ob-  
3 tained from any eligible professional or any  
4 other source.

5 “(ii) USE OF INFORMATION.—Not-  
6 withstanding any other provision of law,  
7 subject to clause (v), the Secretary may  
8 (as the Secretary determines appropriate)  
9 use information collected or obtained pur-  
10 suant to clause (i) in the determination of  
11 relative values for services under this sec-  
12 tion.

13 “(iii) TYPES OF INFORMATION.—The  
14 types of information described in clauses  
15 (i) and (ii) may, at the Secretary’s discre-  
16 tion, include any or all of the following:

17 “(I) Time involved in furnishing  
18 services.

19 “(II) Amounts and types of prac-  
20 tice expense inputs involved with fur-  
21 nishing services.

22 “(III) Prices (net of any dis-  
23 counts) for practice expense inputs,  
24 which may include paid invoice prices  
25 or other documentation or records.

1                   “(IV) Overhead and accounting  
2 information for practices of physicians  
3 and other suppliers.

4                   “(V) Any other element that  
5 would improve the valuation of serv-  
6 ices under this section.

7                   “(iv) INFORMATION COLLECTION  
8 MECHANISMS.—Information may be col-  
9 lected or obtained pursuant to this sub-  
10 paragraph from any or all of the following:

11                   “(I) Surveys of physicians, other  
12 suppliers, providers of services, manu-  
13 facturers, and vendors.

14                   “(II) Surgical logs, billing sys-  
15 tems, or other practice or facility  
16 records.

17                   “(III) Electronic health records.

18                   “(IV) Any other mechanism de-  
19 termined appropriate by the Sec-  
20 retary.

21                   “(v) TRANSPARENCY OF USE OF IN-  
22 FORMATION.—

23                   “(I) IN GENERAL.—Subject to  
24 subclauses (II) and (III), if the Sec-  
25 retary uses information collected or

1           obtained under this subparagraph in  
2           the determination of relative values  
3           under this subsection, the Secretary  
4           shall disclose the information source  
5           and discuss the use of such informa-  
6           tion in such determination of relative  
7           values through notice and comment  
8           rulemaking.

9           “(II) THRESHOLDS FOR USE.—

10          The Secretary may establish thresh-  
11          olds in order to use such information,  
12          including the exclusion of information  
13          collected or obtained from eligible pro-  
14          fessionals who use very high resources  
15          (as determined by the Secretary) in  
16          furnishing a service.

17          “(III) DISCLOSURE OF INFORMA-

18          TION.—The Secretary shall make ag-  
19          gregate information available under  
20          this subparagraph but shall not dis-  
21          close information in a form or manner  
22          that identifies an eligible professional  
23          or a group practice, or information  
24          collected or obtained pursuant to a  
25          nondisclosure agreement.

1           “(vi) INCENTIVE TO PARTICIPATE.—  
2           The Secretary may provide for such pay-  
3           ments under this part to an eligible profes-  
4           sional that submits such solicited informa-  
5           tion under this subparagraph as the Sec-  
6           retary determines appropriate in order to  
7           compensate such eligible professional for  
8           such submission. Such payments shall be  
9           provided in a form and manner specified  
10          by the Secretary.

11          “(vii) ADMINISTRATION.—Chapter 35  
12          of title 44, United States Code, shall not  
13          apply to information collected or obtained  
14          under this subparagraph.

15          “(viii) DEFINITION OF ELIGIBLE PRO-  
16          FESSIONAL.—In this subparagraph, the  
17          term ‘eligible professional’ has the meaning  
18          given such term in subsection (k)(3)(B).

19          “(ix) FUNDING.—For purposes of car-  
20          rying out this subparagraph, in addition to  
21          funds otherwise appropriated, the Sec-  
22          retary shall provide for the transfer, from  
23          the Federal Supplementary Medical Insur-  
24          ance Trust Fund under section 1841, of  
25          \$2,000,000 to the Centers for Medicare &

1 Medicaid Services Program Management  
2 Account for each fiscal year beginning with  
3 fiscal year 2014. Amounts transferred  
4 under the preceding sentence for a fiscal  
5 year shall be available until expended.”.

6 (2) LIMITATION ON REVIEW.—Section  
7 1848(i)(1) of the Social Security Act (42 U.S.C.  
8 1395w-4(i)(1)) is amended—

9 (A) in subparagraph (D), by striking  
10 “and” at the end;

11 (B) in subparagraph (E), by striking the  
12 period at the end and inserting “, and”; and

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

15 “(F) the collection and use of information  
16 in the determination of relative values under  
17 subsection (c)(2)(M).”.

18 (b) AUTHORITY FOR ALTERNATIVE APPROACHES TO  
19 ESTABLISHING PRACTICE EXPENSE RELATIVE VAL-  
20 UES.—Section 1848(c)(2) of the Social Security Act (42  
21 U.S.C. 1395w-4(c)(2)), as amended by subsection (a), is  
22 amended by adding at the end the following new subpara-  
23 graph:

24 “(N) AUTHORITY FOR ALTERNATIVE AP-  
25 PROACHES TO ESTABLISHING PRACTICE EX-

1 PENSE RELATIVE VALUES.—The Secretary may  
2 establish or adjust practice expense relative val-  
3 ues under this subsection using cost, charge, or  
4 other data from suppliers or providers of serv-  
5 ices, including information collected or obtained  
6 under subparagraph (M).”.

7 (c) REVISED AND EXPANDED IDENTIFICATION OF  
8 POTENTIALLY MISVALUED CODES.—Section  
9 1848(c)(2)(K)(ii) of the Social Security Act (42 U.S.C.  
10 1395w-4(c)(2)(K)(ii)) is amended to read as follows:

11 “(ii) IDENTIFICATION OF POTEN-  
12 Tially MISVALUED CODES.—For purposes  
13 of identifying potentially misvalued codes  
14 pursuant to clause (i)(I), the Secretary  
15 shall examine codes (and families of codes  
16 as appropriate) based on any or all of the  
17 following criteria:

18 “(I) Codes that have experienced  
19 the fastest growth.

20 “(II) Codes that have experi-  
21 enced substantial changes in practice  
22 expenses.

23 “(III) Codes that describe new  
24 technologies or services within an ap-  
25 propriate time period (such as 3



1 years) after the relative values are ini-  
2 tially established for such codes.

3 “(IV) Codes which are multiple  
4 codes that are frequently billed in con-  
5 junction with furnishing a single serv-  
6 ice.

7 “(V) Codes with low relative val-  
8 ues, particularly those that are often  
9 billed multiple times for a single treat-  
10 ment.

11 “(VI) Codes that have not been  
12 subject to review since implementation  
13 of the fee schedule.

14 “(VII) Codes that account for  
15 the majority of spending under the  
16 physician fee schedule.

17 “(VIII) Codes for services that  
18 have experienced a substantial change  
19 in the hospital length of stay or proce-  
20 dure time.

21 “(IX) Codes for which there may  
22 be a change in the typical site of serv-  
23 ice since the code was last valued.

24 “(X) Codes for which there is a  
25 significant difference in payment for

1 the same service between different  
2 sites of service.

3 “(XI) Codes for which there may  
4 be anomalies in relative values within  
5 a family of codes.

6 “(XII) Codes for services where  
7 there may be efficiencies when a serv-  
8 ice is furnished at the same time as  
9 other services.

10 “(XIII) Codes with high intra-  
11 service work per unit of time.

12 “(XIV) Codes with high practice  
13 expense relative value units.

14 “(XV) Codes with high cost sup-  
15 plies.

16 “(XVI) Codes as determined ap-  
17 propriate by the Secretary.”

18 (d) TARGET FOR RELATIVE VALUE ADJUSTMENTS  
19 FOR MISVALUED SERVICES.—

20 (1) IN GENERAL.—Section 1848(c)(2) of the  
21 Social Security Act (42 U.S.C. 1395w-4(c)(2)), as  
22 amended by subsections (a) and (b), is amended by  
23 adding at the end the following new subparagraph:

24 “(O) TARGET FOR RELATIVE VALUE AD-  
25 JUSTMENTS FOR MISVALUED SERVICES.—With

1 respect to fee schedules established for each of  
2 2017 through 2020, the following shall apply:

3 “(i) DETERMINATION OF NET REDUC-  
4 TION IN EXPENDITURES.—For each year,  
5 the Secretary shall determine the esti-  
6 mated net reduction in expenditures under  
7 the fee schedule under this section with re-  
8 spect to the year as a result of adjust-  
9 ments to the relative values established  
10 under this paragraph for misvalued codes.

11 “(ii) BUDGET NEUTRAL REDISTRIBU-  
12 TION OF FUNDS IF TARGET MET AND  
13 COUNTING OVERAGES TOWARDS THE TAR-  
14 GET FOR THE SUCCEEDING YEAR.—If the  
15 estimated net reduction in expenditures de-  
16 termined under clause (i) for the year is  
17 equal to or greater than the target for the  
18 year—

19 “(I) reduced expenditures attrib-  
20 utable to such adjustments shall be  
21 redistributed for the year in a budget  
22 neutral manner in accordance with  
23 subparagraph (B)(ii)(II); and

24 “(II) the amount by which such  
25 reduced expenditures exceeds the tar-

1           get for the year shall be treated as a  
2           reduction in expenditures described in  
3           clause (i) for the succeeding year, for  
4           purposes of determining whether the  
5           target has or has not been met under  
6           this subparagraph with respect to that  
7           year.

8           “(iii) EXEMPTION FROM BUDGET  
9           NEUTRALITY IF TARGET NOT MET.—If the  
10          estimated net reduction in expenditures de-  
11          termined under clause (i) for the year is  
12          less than the target for the year, reduced  
13          expenditures in an amount equal to the  
14          target recapture amount shall not be taken  
15          into account in applying subparagraph  
16          (B)(ii)(II) with respect to fee schedules be-  
17          ginning with 2017.

18          “(iv) TARGET RECAPTURE AMOUNT.—  
19          For purposes of clause (iii), the target re-  
20          capture amount is, with respect to a year,  
21          an amount equal to the difference be-  
22          tween—

23                           “(I) the target for the year; and

1                   “(II) the estimated net reduction  
2                   in expenditures determined under  
3                   clause (i) for the year.

4                   “(v) TARGET.—For purposes of this  
5                   subparagraph, with respect to a year, the  
6                   target is calculated as 0.5 percent of the  
7                   estimated amount of expenditures under  
8                   the fee schedule under this section for the  
9                   year.”.

10                   (2) CONFORMING AMENDMENT.—Section  
11                   1848(c)(2)(B)(v) of the Social Security Act (42  
12                   U.S.C. 1395w-4(c)(2)(B)(v)) is amended by adding  
13                   at the end the following new subclause:

14                                   “(VIII) REDUCTIONS FOR  
15                                   MISVALUED SERVICES IF TARGET NOT  
16                                   MET.—Effective for fee schedules be-  
17                                   ginning with 2017, reduced expendi-  
18                                   tures attributable to the application of  
19                                   the target recapture amount described  
20                                   in subparagraph (O)(iii).”.

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

23                                   (1) IN GENERAL.—Section 1848(c) of the So-  
24                   cial Security Act (42 U.S.C. 1395w-4(c)) is amend-

1 ed by adding at the end the following new para-  
2 graph:

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

14 (2) CONFORMING AMENDMENTS.—Section  
15 1848(c)(2) of the Social Security Act (42 U.S.C.  
16 1395w-4(c)(2)) is amended—

17 (A) in subparagraph (B)(ii)(I), by striking  
18 “subclause (II)” and inserting “subclause (II)  
19 and paragraph (7)”; and

20 (B) in subparagraph (K)(iii)(VI)—

21 (i) by striking “provisions of subpara-  
22 graph (B)(ii)(II)” and inserting “provi-  
23 sions of subparagraph (B)(ii)(II) and para-  
24 graph (7)”; and

1 (ii) by striking “under subparagraph  
2 (B)(ii)(II)” and inserting “under subpara-  
3 graph (B)(ii)(I)”.

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

8 (1) in each of clauses (i) and (iii), by striking  
9 “the service” and inserting “the service or group of  
10 services” each place it appears; and

11 (2) in the first sentence of clause (ii), by insert-  
12 ing “or group of services” before the period.

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

15 (1) STUDY.—The Comptroller General of the  
16 United States (in this subsection referred to as the  
17 “Comptroller General”) shall conduct a study of the  
18 processes used by the Relative Value Scale Update  
19 Committee (RUC) to provide recommendations to  
20 the Secretary of Health and Human Services regard-  
21 ing relative values for specific services under the  
22 Medicare physician fee schedule under section 1848  
23 of the Social Security Act (42 U.S.C. 1395w-4).

24 (2) REPORT.—Not later than 1 year after the  
25 date of the enactment of this Act, the Comptroller

1 General shall submit to Congress a report containing  
2 the results of the study conducted under paragraph  
3 (1).

4 (h) ADJUSTMENT TO MEDICARE PAYMENT LOCAL-  
5 ITIES.—

6 (1) IN GENERAL.—Section 1848(e) of the So-  
7 cial Security Act (42 U.S.C. 1395w-4(e)) is amend-  
8 ed by adding at the end the following new para-  
9 graph:

10 “(6) USE OF MSAS AS FEE SCHEDULE AREAS IN  
11 CALIFORNIA.—

12 “(A) IN GENERAL.—Subject to the suc-  
13 ceeding provisions of this paragraph and not-  
14 withstanding the previous provisions of this  
15 subsection, for services furnished on or after  
16 January 1, 2017, the fee schedule areas used  
17 for payment under this section applicable to  
18 California shall be the following:

19 “(i) Each Metropolitan Statistical  
20 Area (each in this paragraph referred to as  
21 an ‘MSA’), as defined by the Director of  
22 the Office of Management and Budget as  
23 of December 31 of the previous year, shall  
24 be a fee schedule area.



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

4           “(B) TRANSITION FOR MSAS PREVIOUSLY  
5           IN REST-OF-STATE PAYMENT LOCALITY OR IN  
6           LOCALITY 3.—

7           “(i) IN GENERAL.—For services fur-  
8           nished in California during a year begin-  
9           ning with 2017 and ending with 2021 in  
10          an MSA in a transition area (as defined in  
11          subparagraph (D)), subject to subpara-  
12          graph (C), the geographic index values to  
13          be applied under this subsection for such  
14          year shall be equal to the sum of the fol-  
15          lowing:

16          “(I) CURRENT LAW COMPO-  
17          NENT.—The old weighting factor (de-  
18          scribed in clause (ii)) for such year  
19          multiplied by the geographic index  
20          values under this subsection for the  
21          fee schedule area that included such  
22          MSA that would have applied in such  
23          area (as estimated by the Secretary)  
24          if this paragraph did not apply.

1                   “(II) MSA-BASED COMPO-  
2                   NENT.—The MSA-based weighting  
3                   factor (described in clause (iii)) for  
4                   such year multiplied by the geographic  
5                   index values computed for the fee  
6                   schedule area under subparagraph (A)  
7                   for the year (determined without re-  
8                   gard to this subparagraph).

9                   “(ii) OLD WEIGHTING FACTOR.—The  
10                  old weighting factor described in this  
11                  clause—

12                                 “(I) for 2017, is  $\frac{5}{6}$ ; and

13                                 “(II) for each succeeding year, is  
14                                 the old weighting factor described in  
15                                 this clause for the previous year  
16                                 minus  $\frac{1}{6}$ .

17                   “(iii) MSA-BASED WEIGHTING FAC-  
18                  TOR.—The MSA-based weighting factor  
19                  described in this clause for a year is 1  
20                  minus the old weighting factor under  
21                  clause (ii) for that year.

22                   “(C) HOLD HARMLESS.—For services fur-  
23                  nished in a transition area in California during  
24                  a year beginning with 2017, the geographic  
25                  index values to be applied under this subsection

1 for such year shall not be less than the cor-  
2 responding geographic index values that would  
3 have applied in such transition area (as esti-  
4 mated by the Secretary) if this paragraph did  
5 not apply.

6 “(D) TRANSITION AREA DEFINED.—In  
7 this paragraph, the term ‘transition area’  
8 means each of the following fee schedule areas  
9 for 2013:

10 “(i) The rest-of-State payment local-  
11 ity.

12 “(ii) Payment locality 3.

13 “(E) REFERENCES TO FEE SCHEDULE  
14 AREAS.—Effective for services furnished on or  
15 after January 1, 2017, for California, any ref-  
16 erence in this section to a fee schedule area  
17 shall be deemed a reference to a fee schedule  
18 area established in accordance with this para-  
19 graph.”.

20 (2) CONFORMING AMENDMENT TO DEFINITION  
21 OF FEE SCHEDULE AREA.—Section 1848(j)(2) of the  
22 Social Security Act (42 U.S.C. 1395w-4(j)(2)) is  
23 amended by striking “The term” and inserting “Ex-  
24 cept as provided in subsection (e)(6)(D), the term”.

1 (i) DISCLOSURE OF DATA USED TO ESTABLISH  
2 MULTIPLE PROCEDURE PAYMENT REDUCTION POLICY.—  
3 The Secretary of Health and Human Services shall make  
4 publicly available the information used to establish the  
5 multiple procedure payment reduction policy to the profes-  
6 sional component of imaging services in the final rule pub-  
7 lished in the Federal Register, v. 77, n. 222, November  
8 16, 2012, pages 68891–69380 under the physician fee  
9 schedule under section 1848 of the Social Security Act (42  
10 U.S.C. 1395w–4).

11 **SEC. 221. MEDICAID DSH.**

12 (a) MODIFICATIONS OF REDUCTIONS TO ALLOT-  
13 MENTS.—Section 1923(f) of the Social Security Act (42  
14 U.S.C. 1396r–4(f)) is amended—

15 (1) in paragraph (7)(A)—

16 (A) in clause (i), by striking “2016  
17 through 2020” and inserting “2017 through  
18 2024”; and

19 (B) in clause (ii), by striking subclauses  
20 (I) through (IV), and inserting the following:

21 “(I) \$1,800,000,000 for fiscal  
22 year 2017;

23 “(II) \$4,700,000,000 for fiscal  
24 year 2018;

1 “(III) \$4,700,000,000 for fiscal  
2 year 2019;

3 “(IV) \$4,700,000,000 for fiscal  
4 year 2020;

5 “(V) \$4,800,000,000 for fiscal  
6 year 2021;

7 “(VI) \$5,000,000,000 for fiscal  
8 year 2022;

9 “(VII) \$5,000,000,000 for fiscal  
10 year 2023; and

11 “(VIII) \$4,400,000,000 for fiscal  
12 year 2024.”; and

13 (2) by striking paragraph (8) and inserting the  
14 following:

15 “(8) CALCULATION OF DSH ALLOTMENTS  
16 AFTER REDUCTIONS PERIOD.—The DSH allotment  
17 for a State for fiscal years after fiscal year 2024  
18 shall be calculated under paragraph (3) without re-  
19 gard to paragraph (7).”.

20 (b) MACPAC REVIEW AND REPORT.—Section  
21 1900(b)(6) of the Social Security Act (42 U.S.C.  
22 1396(b)(6)) is amended—

23 (1) by striking “MACPAC shall consult” and  
24 inserting the following:

1           “(A) IN GENERAL.—MACPAC shall con-  
2           sult”; and

3           (2) by adding at the end the following:

4           “(B) REVIEW AND REPORTS REGARDING  
5           MEDICAID DSH.—

6                   “(i) IN GENERAL.—MACPAC shall  
7                   review and submit an annual report to  
8                   Congress on disproportionate share hos-  
9                   pital payments under section 1923. Each  
10                  report shall include the information speci-  
11                  fied in clause (ii).

12                   “(ii) REQUIRED REPORT INFORMA-  
13                  TION.—Each report required under this  
14                  subparagraph shall include the following:

15                           “(I) Data relating to changes in  
16                           the number of uninsured individuals.

17                           “(II) Data relating to the  
18                           amount and sources of hospitals’ un-  
19                           compensated care costs, including the  
20                           amount of such costs that are the re-  
21                           sult of providing unreimbursed or  
22                           under-reimbursed services, charity  
23                           care, or bad debt.

24                           “(III) Data identifying hospitals  
25                           with high levels of uncompensated

1 care that also provide access to essen-  
2 tial community services for low-in-  
3 come, uninsured, and vulnerable popu-  
4 lations, such as graduate medical edu-  
5 cation, and the continuum of primary  
6 through quaternary care, including  
7 the provision of trauma care and pub-  
8 lic health services.

9 “(IV) State-specific analyses re-  
10 garding the relationship between the  
11 most recent State DSH allotment and  
12 the projected State DSH allotment for  
13 the succeeding year and the data re-  
14 ported under subclauses (I), (II), and  
15 (III) for the State.

16 “(iii) DATA.—Notwithstanding any  
17 other provision of law, the Secretary regu-  
18 larly shall provide MACPAC with the most  
19 recent State reports and most recent inde-  
20 pendent certified audits submitted under  
21 section 1923(j), cost reports submitted  
22 under title XVIII, and such other data as  
23 MACPAC may request for purposes of con-  
24 ducting the reviews and preparing and sub-

1           mitting the annual reports required under  
2           this subparagraph.

3           “(iv) SUBMISSION DEADLINES.—The  
4           first report required under this subpara-  
5           graph shall be submitted to Congress not  
6           later than February 1, 2016. Subsequent  
7           reports shall be submitted as part of, or  
8           with, each annual report required under  
9           paragraph (1)(C) during the period of fis-  
10          cal years 2017 through 2024.”.

11 **SEC. 222. REALIGNMENT OF THE MEDICARE SEQUESTER**  
12 **FOR FISCAL YEAR 2024.**

13          Paragraph (6) (relating to implementing direct  
14 spending reductions) of section 251A of the Balanced  
15 Budget and Emergency Deficit Control Act of 1985 (2  
16 U.S.C. 901a) is amended by adding at the end the fol-  
17 lowing new subparagraph:

18           “(D) Notwithstanding the 2 percent limit speci-  
19           fied in subparagraph (A) for payments for the Medi-  
20           care programs specified in section 256(d), the se-  
21           questration order of the President under such sub-  
22           paragraph for fiscal year 2024 shall be applied to  
23           such payments so that—

24           “(i) with respect to the first 6 months in  
25           which such order is effective for such fiscal



1 year, the payment reduction shall be 4.0 per-  
2 cent; and

3 “(ii) with respect to the second 6 months  
4 in which such order is so effective for such fis-  
5 cal year, the payment reduction shall be 0.0  
6 percent.”.

7 **SEC. 223. DEMONSTRATION PROGRAMS TO IMPROVE COM-**  
8 **MUNITY MENTAL HEALTH SERVICES.**

9 (a) **CRITERIA FOR CERTIFIED COMMUNITY BEHAV-**  
10 **IORAL HEALTH CLINICS TO PARTICIPATE IN DEM-**  
11 **ONSTRATION PROGRAMS.—**

12 (1) **PUBLICATION.—**Not later than September  
13 1, 2015, the Secretary shall publish criteria for a  
14 clinic to be certified by a State as a certified com-  
15 munity behavioral health clinic for purposes of par-  
16 ticipating in a demonstration program conducted  
17 under subsection (d).

18 (2) **REQUIREMENTS.—**The criteria published  
19 under this subsection shall include criteria with re-  
20 spect to the following:

21 (A) **STAFFING.—**Staffing requirements, in-  
22 cluding criteria that staff have diverse discipli-  
23 nary backgrounds, have necessary State-re-  
24 quired license and accreditation, and are cul-

1           turally and linguistically trained to serve the  
2           needs of the clinic’s patient population.

3           (B) AVAILABILITY AND ACCESSIBILITY OF  
4           SERVICES.—Availability and accessibility of  
5           services, including crisis management services  
6           that are available and accessible 24 hours a  
7           day, the use of a sliding scale for payment, and  
8           no rejection for services or limiting of services  
9           on the basis of a patient’s ability to pay or a  
10          place of residence.

11          (C) CARE COORDINATION.—Care coordina-  
12          tion, including requirements to coordinate care  
13          across settings and providers to ensure seamless  
14          transitions for patients across the full spectrum  
15          of health services including acute, chronic, and  
16          behavioral health needs. Care coordination re-  
17          quirements shall include partnerships or formal  
18          contracts with the following:

19                 (i) Federally-qualified health centers  
20                 (and as applicable, rural health clinics) to  
21                 provide Federally-qualified health center  
22                 services (and as applicable, rural health  
23                 clinic services) to the extent such services  
24                 are not provided directly through the cer-  
25                 tified community behavioral health clinic.

1 (ii) Inpatient psychiatric facilities and  
2 substance use detoxification, post-detoxi-  
3 fication step-down services, and residential  
4 programs.

5 (iii) Other community or regional  
6 services, supports, and providers, including  
7 schools, child welfare agencies, juvenile and  
8 criminal justice agencies and facilities, In-  
9 dian Health Service youth regional treat-  
10 ment centers, State licensed and nationally  
11 accredited child placing agencies for thera-  
12 peutic foster care service, and other social  
13 and human services.

14 (iv) Department of Veterans Affairs  
15 medical centers, independent outpatient  
16 clinics, drop-in centers, and other facilities  
17 of the Department as defined in section  
18 1801 of title 38, United States Code.

19 (v) Inpatient acute care hospitals and  
20 hospital outpatient clinics.

21 (D) SCOPE OF SERVICES.—Provision (in a  
22 manner reflecting person-centered care) of the  
23 following services which, if not available directly  
24 through the certified community behavioral

1 health clinic, are provided or referred through  
2 formal relationships with other providers:

3 (i) Crisis mental health services, in-  
4 cluding 24-hour mobile crisis teams, emer-  
5 gency crisis intervention services, and cri-  
6 sis stabilization.

7 (ii) Screening, assessment, and diag-  
8 nosis, including risk assessment.

9 (iii) Patient-centered treatment plan-  
10 ning or similar processes, including risk as-  
11 sessment and crisis planning.

12 (iv) Outpatient mental health and  
13 substance use services.

14 (v) Outpatient clinic primary care  
15 screening and monitoring of key health in-  
16 dicators and health risk.

17 (vi) Targeted case management.

18 (vii) Psychiatric rehabilitation serv-  
19 ices.

20 (viii) Peer support and counselor serv-  
21 ices and family supports.

22 (ix) Intensive, community-based men-  
23 tal health care for members of the armed  
24 forces and veterans, particularly those  
25 members and veterans located in rural

1 areas, provided the care is consistent with  
2 minimum clinical mental health guidelines  
3 promulgated by the Veterans Health Ad-  
4 ministration including clinical guidelines  
5 contained in the Uniform Mental Health  
6 Services Handbook of such Administration.

7 (E) QUALITY AND OTHER REPORTING.—

8 Reporting of encounter data, clinical outcomes  
9 data, quality data, and such other data as the  
10 Secretary requires.

11 (F) ORGANIZATIONAL AUTHORITY.—Cri-

12 teria that a clinic be a non-profit or part of a  
13 local government behavioral health authority or  
14 operated under the authority of the Indian  
15 Health Service, an Indian tribe or tribal organi-  
16 zation pursuant to a contract, grant, coopera-  
17 tive agreement, or compact with the Indian  
18 Health Service pursuant to the Indian Self-De-  
19 termination Act (25 U.S.C. 450 et seq.), or an  
20 urban Indian organization pursuant to a grant  
21 or contract with the Indian Health Service  
22 under title V of the Indian Health Care Im-  
23 provement Act (25 U.S.C. 1601 et seq.).

1 (b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE  
2 PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRA-  
3 TION PROGRAMS.—

4 (1) IN GENERAL.—Not later than September 1,  
5 2015, the Secretary, through the Administrator of  
6 the Centers for Medicare & Medicaid Services, shall  
7 issue guidance for the establishment of a prospective  
8 payment system that shall only apply to medical as-  
9 sistance for mental health services furnished by a  
10 certified community behavioral health clinic partici-  
11 pating in a demonstration program under subsection  
12 (d).

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

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

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

24 (c) PLANNING GRANTS.—

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

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

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

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

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

21           (d) DEMONSTRATION PROGRAMS.—

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

1 (c), meet the requirements of this subsection, and  
2 represent a diverse selection of geographic areas, in-  
3 cluding rural and underserved areas.

4 (2) APPLICATION REQUIREMENTS.—

5 (A) IN GENERAL.—The Secretary shall so-  
6 licit applications to participate in demonstration  
7 programs under this subsection solely from  
8 States awarded planning grants under sub-  
9 section (c).

10 (B) REQUIRED INFORMATION.—An appli-  
11 cation for a demonstration program under this  
12 subsection shall include the following:

13 (i) The target Medicaid population to  
14 be served under the demonstration pro-  
15 gram.

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

18 (iii) Verification that the State has  
19 certified a participating clinic as a certified  
20 community behavioral health clinic in ac-  
21 cordance with the requirements of sub-  
22 section (b).

23 (iv) A description of the scope of the  
24 mental health services available under the  
25 State Medicaid program that will be paid



1 for under the prospective payment system  
2 tested in the demonstration program.

3 (v) Verification that the State has  
4 agreed to pay for such services at the rate  
5 established under the prospective payment  
6 system.

7 (vi) Such other information as the  
8 Secretary may require relating to the dem-  
9 onstration program including with respect  
10 to determining the soundness of the pro-  
11 posed prospective payment system.

12 (3) NUMBER AND LENGTH OF DEMONSTRATION  
13 PROGRAMS.—Not more than 8 States shall be se-  
14 lected for 2-year demonstration programs under this  
15 subsection.

16 (4) REQUIREMENTS FOR SELECTING DEM-  
17 ONSTRATION PROGRAMS.—

18 (A) IN GENERAL.—The Secretary shall  
19 give preference to selecting demonstration pro-  
20 grams where participating certified community  
21 behavioral health clinics—

22 (i) provide the most complete scope of  
23 services described in subsection (a)(2)(D)  
24 to individuals eligible for medical assist-  
25 ance under the State Medicaid program;

1 (ii) will improve availability of, access  
2 to, and participation in, services described  
3 in subsection (a)(2)(D) to individuals eligi-  
4 ble for medical assistance under the State  
5 Medicaid program;

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

9 (iv) demonstrate the potential to ex-  
10 pand available mental health services in a  
11 demonstration area and increase the qual-  
12 ity of such services without increasing net  
13 Federal spending.

14 (5) PAYMENT FOR MEDICAL ASSISTANCE FOR  
15 MENTAL HEALTH SERVICES PROVIDED BY CER-  
16 TIFIED COMMUNITY BEHAVIORAL HEALTH CLIN-  
17 ICS.—

18 (A) IN GENERAL.—The Secretary shall pay  
19 a State participating in a demonstration pro-  
20 gram under this subsection the Federal match-  
21 ing percentage specified in subparagraph (B)  
22 for amounts expended by the State to provide  
23 medical assistance for mental health services  
24 described in the demonstration program appli-  
25 cation in accordance with paragraph (2)(B)(iv)

1 that are provided by certified community behav-  
2 ioral health clinics to individuals who are en-  
3 rolled in the State Medicaid program. Payments  
4 to States made under this paragraph shall be  
5 considered to have been under, and are subject  
6 to the requirements of, section 1903 of the So-  
7 cial Security Act (42 U.S.C. 1396b).

8 (B) FEDERAL MATCHING PERCENTAGE.—

9 The Federal matching percentage specified in  
10 this subparagraph is with respect to medical as-  
11 sistance described in subparagraph (A) that is  
12 furnished—

13 (i) to a newly eligible individual de-  
14 scribed in paragraph (2) of section 1905(y)  
15 of the Social Security Act (42 U.S.C.  
16 1396d(y)), the matching rate applicable  
17 under paragraph (1) of that section; and

18 (ii) to an individual who is not a  
19 newly eligible individual (as so described)  
20 but who is eligible for medical assistance  
21 under the State Medicaid program, the en-  
22 hanced FMAP applicable to the State.

23 (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

1 demonstration program under this sub-  
2 section and in areas of a demonstration  
3 State that are not participating in the  
4 demonstration program; and

5 (iii) an assessment of the impact of  
6 the demonstration programs on the Fed-  
7 eral and State costs of a full range of men-  
8 tal health services (including inpatient,  
9 emergency and ambulatory services).

10 (B) RECOMMENDATIONS.—Not later than  
11 December 31, 2021, the Secretary shall submit  
12 to Congress recommendations concerning  
13 whether the demonstration programs under this  
14 section should be continued, expanded, modi-  
15 fied, or terminated.

16 (e) DEFINITIONS.—In this section:

17 (1) FEDERALLY-QUALIFIED HEALTH CENTER  
18 SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER;  
19 RURAL HEALTH CLINIC SERVICES; RURAL HEALTH  
20 CLINIC.—The terms “Federally-qualified health cen-  
21 ter services”, “Federally-qualified health center”,  
22 “rural health clinic services”, and “rural health clin-  
23 ic” have the meanings given those terms in section  
24 1905(l) of the Social Security Act (42 U.S.C.  
25 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;

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).

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