

114TH CONGRESS  
2D SESSION

# H. R. 5273

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IN THE SENATE OF THE UNITED STATES

JUNE 8, 2016

Received; read twice and referred to the Committee on Finance

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## AN ACT

To amend title XVIII of the Social Security Act to provide for regulatory relief under the Medicare program for certain providers of services and suppliers and increased transparency in hospital coding and enrollment data, 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,*

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

2 (a) **SHORT TITLE.**—This Act may be cited as the  
3 “Helping Hospitals Improve Patient Care Act of 2016”.

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

Sec. 1. Short title; table of contents.

**TITLE I—PROVISIONS RELATING TO MEDICARE PART A**

- Sec. 101. Development of Medicare study for HCPCS version of MS-DRG codes for similar hospital services.  
Sec. 102. Establishing beneficiary equity in the Medicare hospital readmission program.  
Sec. 103. Five-year extension of the rural community hospital demonstration program.  
Sec. 104. Regulatory relief for LTCHs.  
Sec. 105. Savings from IPPS MACRA pay-for through not applying documentation and coding adjustments.

**TITLE II—PROVISIONS RELATING TO MEDICARE PART B**

- Sec. 201. Continuing Medicare payment under HOPD prospective payment system for services furnished by mid-build off-campus outpatient departments of providers.  
Sec. 202. Treatment of cancer hospitals in off-campus outpatient department of a provider policy.  
Sec. 203. Treatment of eligible professionals in ambulatory surgical centers for meaningful use and MIPS.

**TITLE III—OTHER MEDICARE PROVISIONS**

- Sec. 301. Delay in authority to terminate contracts for Medicare Advantage plans failing to achieve minimum quality ratings.  
Sec. 302. Requirement for enrollment data reporting for Medicare.  
Sec. 303. Updating the Welcome to Medicare package.

1 **TITLE I—PROVISIONS RELATING**  
2 **TO MEDICARE PART A**

3 **SEC. 101. DEVELOPMENT OF MEDICARE STUDY FOR HCPCS**  
4 **VERSION OF MS-DRG CODES FOR SIMILAR**  
5 **HOSPITAL SERVICES.**

6 Section 1886 of the Social Security Act (42 U.S.C.  
7 1395ww) is amended by adding at the end the following  
8 new subsection:

9 “(t) RELATING SIMILAR INPATIENT AND OUT-  
10 PATIENT HOSPITAL SERVICES.—

11 “(1) DEVELOPMENT OF HCPCS VERSION OF  
12 MS-DRG CODES.—

13 “(A) IN GENERAL.—Not later than Janu-  
14 ary 1, 2018, the Secretary shall develop  
15 HCPCS versions for MS-DRGs that is similar  
16 to the ICD-10-PCS for such MS-DRGs such  
17 that, to the extent possible, the MS-DRG as-  
18 signment shall be similar for a claim coded with  
19 the HCPCS version as an identical claim coded  
20 with a ICD-10-PCS code.

21 “(B) COVERAGE OF SURGICAL MS-DRGS.—  
22 In carrying out subparagraph (A), the Sec-  
23 retary shall develop HCPCS versions of MS-  
24 DRG codes for not fewer than 10 surgical MS-  
25 DRGs.

1                   “(C) PUBLICATION AND DISSEMINATION  
2 OF THE HCPCS VERSIONS OF MS-DRGS.—

3                   “(i) IN GENERAL.—The Secretary  
4 shall develop a HCPCS MS-DRG defini-  
5 tions manual and software that is similar  
6 to the definitions manual and software for  
7 ICD-10-PCS codes for such MS-DRGs.  
8 The Secretary shall post the HCPCS MS-  
9 DRG definitions manual and software on  
10 the Internet website of the Centers for  
11 Medicare & Medicaid Services. The  
12 HCPCS MS-DRG definitions manual and  
13 software shall be in the public domain and  
14 available for use and redistribution without  
15 charge.

16                   “(ii) USE OF PREVIOUS ANALYSIS  
17 DONE BY MEDPAC.—In developing the  
18 HCPCS MS-DRG definitions manual and  
19 software under clause (i), the Secretary  
20 shall consult with the Medicare Payment  
21 Advisory Commission and shall consider  
22 the analysis done by such Commission in  
23 translating outpatient surgical claims into  
24 inpatient surgical MS-DRGs in preparing  
25 chapter 7 (relating to hospital short-stay

1 policy issues) of its ‘Medicare and the  
2 Health Care Delivery System’ report sub-  
3 mitted to Congress in June 2015.

4 “(D) DEFINITION AND REFERENCE.—In  
5 this paragraph:

6 “(i) HCPCS.—The term ‘HCPCS’  
7 means, with respect to hospital items and  
8 services, the code under the Healthcare  
9 Common Procedure Coding System  
10 (HCPCS) (or a successor code) for such  
11 items and services.

12 “(ii) ICD–10–PCS.—The term ‘ICD–  
13 10–PCS’ means the International Classi-  
14 fication of Diseases, 10th Revision, Proce-  
15 dure Coding System, and includes a subse-  
16 quent revision of such International Classi-  
17 fication of Diseases, Procedure Coding  
18 System.”.

19 **SEC. 102. ESTABLISHING BENEFICIARY EQUITY IN THE**  
20 **MEDICARE HOSPITAL READMISSION PRO-**  
21 **GRAM.**

22 (a) TRANSITIONAL ADJUSTMENT FOR DUAL ELIGI-  
23 BLE POPULATION.—Section 1886(q)(3) of the Social Se-  
24 curity Act (42 U.S.C. 1395ww(q)(3)) is amended—

1           (1) in subparagraph (A), by inserting “subject  
2           to subparagraph (D),” after “purposes of paragraph  
3           (1),”; and

4           (2) by adding at the end the following new sub-  
5           paragraph:

6                   “(D) TRANSITIONAL ADJUSTMENT FOR  
7                   DUAL ELIGIBLES.—

8                           “(i) IN GENERAL.—In determining a  
9                           hospital’s adjustment factor under this  
10                           paragraph for purposes of making pay-  
11                           ments for discharges occurring during and  
12                           after fiscal year 2019, and before the ap-  
13                           plication of clause (i) of subparagraph (E),  
14                           the Secretary shall assign hospitals to  
15                           groups (as defined by the Secretary under  
16                           clause (ii)) and apply the applicable provi-  
17                           sions of this subsection using a method-  
18                           ology in a manner that allows for separate  
19                           comparison of hospitals within each such  
20                           group, as determined by the Secretary.

21                           “(ii) DEFINING GROUPS.—For pur-  
22                           poses of this subparagraph, the Secretary  
23                           shall define groups of hospitals based on  
24                           their overall proportion, of the inpatients  
25                           who are entitled to, or enrolled for, bene-

1 fits under part A, who are full-benefit dual  
2 eligible individuals (as defined in section  
3 1935(c)(6)). In defining groups, the Sec-  
4 retary shall consult the Medicare Payment  
5 Advisory Commission and may consider  
6 the analysis done by such Commission in  
7 preparing the portion of its report sub-  
8 mitted to Congress in June 2013 relating  
9 to readmissions.

10 “(iii) MINIMIZING REPORTING BUR-  
11 DEN ON HOSPITALS.—In carrying out this  
12 subparagraph, the Secretary shall not im-  
13 pose any additional reporting requirements  
14 on hospitals.

15 “(iv) BUDGET NEUTRAL DESIGN  
16 METHODOLOGY.—The Secretary shall de-  
17 sign the methodology to implement this  
18 subparagraph so that the estimated total  
19 amount of reductions in payments under  
20 this subsection equals the estimated total  
21 amount of reductions in payments that  
22 would otherwise occur under this sub-  
23 section if this subparagraph did not  
24 apply.”.

1 (b) SUBSEQUENT ADJUSTMENTS BASED ON IM-  
2 PACT REPORTS.—Section 1886(q)(3) of the Social Secu-  
3 rity Act (42 U.S.C. 1395ww(q)(3)), as amended by sub-  
4 section (a), is further amended by adding at the end the  
5 following new subparagraph:

6 (E) CHANGES IN RISK ADJUSTMENT.—  
7 (i) CONSIDERATION OF REC-  
8 OMMENDATIONS IN IMPACT REPORTS.—  
9 The Secretary may take into account the  
10 studies conducted and the recommenda-  
11 tions made by the Secretary under section  
12 2(d)(1) of the IMPACT Act of 2014 (Pub-  
13 lic Law 113–185; 42 U.S.C. 1395lll note)  
14 with respect to the application under this  
15 subsection of risk adjustment methodolo-  
16 gies. Nothing in this clause shall be con-  
17 strued as precluding consideration of the  
18 use of groupings of hospitals.”.

19 (c) MEDPAC STUDY ON READMISSIONS PROGRAM.—  
20 The Medicare Payment Advisory Commission shall con-  
21 duct a study to review overall hospital readmissions de-  
22 scribed in section 1886(q)(5)(E) of the Social Security Act  
23 (42 U.S.C. 1395ww(q)(5)(E)) and whether such readmis-  
24 sions are related to any changes in outpatient and emer-  
25 gency services furnished. The Commission shall submit to



1 Congress a report on such study in its report to Congress  
2 in June 2017.

3 (d) ADDRESSING ISSUE OF CERTAIN PATIENTS.—  
4 Subparagraph (E) of section 1886(q)(3) of the Social Se-  
5 curity Act (42 U.S.C. 1395ww(q)(3)), as added by sub-  
6 section (b), is further amended by adding at the end the  
7 following new clause:

8 “(ii) CONSIDERATION OF EXCLUSION  
9 OF PATIENT CASES BASED ON V OR OTHER  
10 APPROPRIATE CODES.—In promulgating  
11 regulations to carry out this subsection  
12 with respect to discharges occurring after  
13 fiscal year 2018, the Secretary may con-  
14 sider the use of V or other ICD-related  
15 codes for removal of a readmission. The  
16 Secretary may consider modifying meas-  
17 ures under this subsection to incorporate V  
18 or other ICD-related codes at the same  
19 time as other changes are being made  
20 under this subparagraph.”.

21 (e) REMOVAL OF CERTAIN READMISSIONS.—Sub-  
22 paragraph (E) of section 1886(q)(3) of the Social Security  
23 Act (42 U.S.C. 1395ww(q)(3)), as added by subsection (b)  
24 and amended by subsection (d), is further amended by  
25 adding at the end the following new clause:

1                   “(iii) REMOVAL OF CERTAIN RE-  
2                   ADMISSIONS.—In promulgating regulations  
3                   to carry out this subsection, with respect  
4                   to discharges occurring after fiscal year  
5                   2018, the Secretary may consider removal  
6                   as a readmission of an admission that is  
7                   classified within one or more of the fol-  
8                   lowing: transplants, end-stage renal dis-  
9                   ease, burns, trauma, psychosis, or sub-  
10                  stance abuse. The Secretary may consider  
11                  modifying measures under this subsection  
12                  to remove readmissions at the same time  
13                  as other changes are being made under  
14                  this subparagraph.”.

15 **SEC. 103. FIVE-YEAR EXTENSION OF THE RURAL COMMU-  
16                    NITY HOSPITAL DEMONSTRATION PROGRAM.**

17                  (a) EXTENSION.—Section 410A of the Medicare Pre-  
18                  scription Drug, Improvement, and Modernization Act of  
19                  2003 (Public Law 108–173; 42 U.S.C. 1395ww note), as  
20                  amended by sections 3123 and 10313 of the Patient Pro-  
21                  tection and Affordable Care Act (Public Law 111–148),  
22                  is amended—

23                         (1) in subsection (a)(5), by striking “5-year ex-  
24                         tension period” and inserting “10-year extension pe-  
25                         riod”; and

1 (2) in subsection (g)—

2 (A) in the subsection heading, by striking  
3 “FIVE-YEAR” and inserting “TEN-YEAR”;

4 (B) in paragraph (1), by striking “addi-  
5 tional 5-year” and inserting “additional 10-  
6 year”;

7 (C) by striking “5-year extension period”  
8 and inserting “10-year extension period” each  
9 place it appears;

10 (D) in paragraph (4)(B)—

11 (i) in the matter preceding clause (i),  
12 by inserting “each 5-year period in” after  
13 “hospital during”; and

14 (ii) in clause (i), by inserting “each  
15 applicable 5-year period in” after “the first  
16 day of”; and

17 (E) by adding at the end the following new  
18 paragraphs:

19 “(5) OTHER HOSPITALS IN DEMONSTRATION  
20 PROGRAM.—During the second 5 years of the 10-  
21 year extension period, the Secretary shall apply the  
22 provisions of paragraph (4) to rural community hos-  
23 pitals that are not described in paragraph (4) but  
24 are participating in the demonstration program  
25 under this section as of December 30, 2014, in a

1 similar manner as such provisions apply to rural  
2 community hospitals described in paragraph (4).

3 “(6) EXPANSION OF DEMONSTRATION PROGRAM  
4 TO RURAL AREAS IN ANY STATE.—

5 “(A) IN GENERAL.—The Secretary shall,  
6 notwithstanding subsection (a)(2) or paragraph  
7 (2) of this subsection, not later than 120 days  
8 after the date of the enactment of this para-  
9 graph, issue a solicitation for applications to se-  
10 lect up to the maximum number of additional  
11 rural community hospitals located in any State  
12 to participate in the demonstration program  
13 under this section for the second 5 years of the  
14 10-year extension period without exceeding the  
15 limitation under paragraph (3) of this sub-  
16 section.

17 “(B) PRIORITY.—In determining which  
18 rural community hospitals that submitted an  
19 application pursuant to the solicitation under  
20 subparagraph (A) to select for participation in  
21 the demonstration program, the Secretary—

22 “(i) shall give priority to rural com-  
23 munity hospitals located in one of the 20  
24 States with the lowest population densities  
25 (as determined by the Secretary using the

1                   2015 Statistical Abstract of the United  
2                   States); and

3                   “(ii) may consider—

4                                 “(I) closures of hospitals located  
5                                 in rural areas in the State in which  
6                                 the rural community hospital is lo-  
7                                 cated during the 5-year period imme-  
8                                 diately preceding the date of the en-  
9                                 actment of this paragraph; and

10                                “(II) the population density of  
11                                the State in which the rural commu-  
12                                nity hospital is located.”.

13           (b) CHANGE IN TIMING FOR REPORT.—Subsection  
14 (e) of such section 410A is amended—

15                   (1) by striking “Not later than 6 months after  
16                   the completion of the demonstration program under  
17                   this section” and inserting “Not later than August  
18                   1, 2018”; and

19                   (2) by striking “such program” and inserting  
20                   “the demonstration program under this section”.

21 **SEC. 104. REGULATORY RELIEF FOR LTCHS.**

22           (a) TECHNICAL CHANGE TO THE MEDICARE LONG-  
23 TERM CARE HOSPITAL MORATORIUM EXCEPTION.—

24                   (1) IN GENERAL.—Section 114(d)(7) of the  
25                   Medicare, Medicaid, and SCHIP Extension Act of

1 2007 (42 U.S.C. 1395ww note), as amended by sec-  
2 tions 3106(b) and 10312(b) of Public Law 111–148,  
3 section 1206(b)(2) of the Pathway for SGR Reform  
4 Act of 2013 (division B of Public Law 113–67), and  
5 section 112 of the Protecting Access to Medicare Act  
6 of 2014, is amended by striking “The moratorium  
7 under paragraph (1)(A)” and inserting “Any mora-  
8 torium under paragraph (1)”.

9 (2) EFFECTIVE DATE.—The amendment made  
10 by paragraph (1) shall take effect as if included in  
11 the enactment of section 112 of the Protecting Ac-  
12 cess to Medicare Act of 2014.

13 (b) MODIFICATION TO MEDICARE LONG-TERM CARE  
14 HOSPITAL HIGH COST OUTLIER PAYMENTS.—Section  
15 1886(m) of the Social Security Act (42 U.S.C.  
16 1395ww(m)) is amended by adding at the end the fol-  
17 lowing new paragraph:

18 “(7) TREATMENT OF HIGH COST OUTLIER PAY-  
19 MENTS.—

20 “(A) ADJUSTMENT TO THE STANDARD  
21 FEDERAL PAYMENT RATE FOR ESTIMATED  
22 HIGH COST OUTLIER PAYMENTS.—Under the  
23 system described in paragraph (1), for fiscal  
24 years beginning on or after October 1, 2017,  
25 the Secretary shall reduce the standard Federal

1 payment rate as if the estimated aggregate  
2 amount of high cost outlier payments for stand-  
3 ard Federal payment rate discharges for each  
4 such fiscal year would be equal to 8 percent of  
5 estimated aggregate payments for standard  
6 Federal payment rate discharges for each such  
7 fiscal year.

8 “(B) LIMITATION ON HIGH COST OUTLIER  
9 PAYMENT AMOUNTS.—Notwithstanding sub-  
10 paragraph (A), the Secretary shall set the fixed  
11 loss amount for high cost outlier payments such  
12 that the estimated aggregate amount of high  
13 cost outlier payments made for standard Fed-  
14 eral payment rate discharges for fiscal years be-  
15 ginning on or after October 1, 2017, shall be  
16 equal to 99.6875 percent of 8 percent of esti-  
17 mated aggregate payments for standard Fed-  
18 eral payment rate discharges for each such fis-  
19 cal year.

20 “(C) WAIVER OF BUDGET NEUTRALITY.—  
21 Any reduction in payments resulting from the  
22 application of subparagraph (B) shall not be  
23 taken into account in applying any budget neu-  
24 trality provision under such system.

1           “(D) NO EFFECT ON SITE NEUTRAL HIGH  
2           COST OUTLIER PAYMENT RATE.—This para-  
3           graph shall not apply with respect to the com-  
4           putation of the applicable site neutral payment  
5           rate under paragraph (6).”.

6 **SEC. 105. SAVINGS FROM IPSS MACRA PAY-FOR THROUGH**  
7           **NOT APPLYING DOCUMENTATION AND COD-**  
8           **ING ADJUSTMENTS.**

9           Section 7(b)(1)(B)(iii) of the TMA, Abstinence Edu-  
10          cation, and QI Programs Extension Act of 2007 (Public  
11          Law 110–90), as amended by section 631(b) of the Amer-  
12          ican Taxpayer Relief Act of 2012 (Public Law 122–240)  
13          and section 414(1)(B)(iii) of the Medicare Access and  
14          CHIP Reauthorization Act of 2015 (Public Law 114–10),  
15          is amended by striking “an increase of 0.5 percentage  
16          points for discharges occurring during each of fiscal years  
17          2018 through 2023” and inserting “an increase of 0.4590  
18          percentage points for discharges occurring during fiscal  
19          year 2018 and 0.5 percentage points for discharges occur-  
20          ring during each of fiscal years 2019 through 2023”.



1 **TITLE II—PROVISIONS RELAT-**  
2 **ING TO MEDICARE PART B**

3 **SEC. 201. CONTINUING MEDICARE PAYMENT UNDER HOPD**  
4 **PROSPECTIVE PAYMENT SYSTEM FOR SERV-**  
5 **ICES FURNISHED BY MID-BUILD OFF-CAMPUS**  
6 **OUTPATIENT DEPARTMENTS OF PROVIDERS.**

7 (a) IN GENERAL.—Section 1833(t)(21) of the Social  
8 Security Act (42 U.S.C. 1395l(t)(21)) is amended—

9 (1) in subparagraph (B)—

10 (A) in clause (i), by striking “clause (ii)”  
11 and inserting “the subsequent provisions of this  
12 subparagraph”; and

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

15 “(iii) DEEMED TREATMENT FOR  
16 2017.—For purposes of applying clause (ii)  
17 with respect to applicable items and serv-  
18 ices furnished during 2017, a department  
19 of a provider (as so defined) not described  
20 in such clause is deemed to be billing  
21 under this subsection with respect to cov-  
22 ered OPD services furnished prior to No-  
23 vember 2, 2015, if the Secretary received  
24 from the provider prior to December 2,  
25 2015, an attestation (pursuant to section

1 413.65(b)(3) of title 42 of the Code of  
2 Federal Regulations) that such department  
3 was a department of a provider (as so de-  
4 fined).

5 “(iv) ALTERNATIVE EXCEPTION BE-  
6 GINNING WITH 2018.—For purposes of  
7 paragraph (1)(B)(v) and this paragraph  
8 with respect to applicable items and serv-  
9 ices furnished during 2018 or a subsequent  
10 year, the term ‘off-campus outpatient de-  
11 partment of a provider’ also shall not in-  
12 clude a department of a provider (as so de-  
13 fined) that is not described in clause (ii)  
14 if—

15 “(I) the Secretary receives from  
16 the provider an attestation (pursuant  
17 to such section 413.65(b)(3)) not later  
18 than December 31, 2016 (or, if later,  
19 60 days after the date of the enact-  
20 ment of this clause), that such depart-  
21 ment met the requirements of a de-  
22 partment of a provider specified in  
23 section 413.65 of title 42 of the Code  
24 of Federal Regulations;

1           “(II) the provider includes such  
2           department as part of the provider on  
3           its enrollment form in accordance with  
4           the enrollment process under section  
5           1866(j); and

6           “(III) the department met the  
7           mid-build requirement of clause (v)  
8           and the Secretary receives, not later  
9           than 60 days after the date of the en-  
10          actment of this clause, from the chief  
11          executive officer or chief operating of-  
12          ficer of the provider a written certifi-  
13          cation that the department met such  
14          requirement.

15          “(v) MID-BUILD REQUIREMENT DE-  
16          SCRIBED.—The mid-build requirement of  
17          this clause is, with respect to a department  
18          of a provider, that before November 2,  
19          2015, the provider had a binding written  
20          agreement with an outside unrelated party  
21          for the actual construction of such depart-  
22          ment.

23          “(vii) AUDIT.—Not later than Decem-  
24          ber 31, 2018, the Secretary shall audit the  
25          compliance with requirements of clause (iv)

1 with respect to each department of a pro-  
2 vider to which such clause applies. If the  
3 Secretary finds as a result of an audit  
4 under this clause that the applicable re-  
5 quirements were not met with respect to  
6 such department, the department shall not  
7 be excluded from the term ‘off-campus out-  
8 patient department of a provider’ under  
9 such clause.

10 “(viii) IMPLEMENTATION.—For pur-  
11 poses of implementing clauses (iii) through  
12 (vii):

13 “(I) Notwithstanding any other  
14 provision of law, the Secretary may  
15 implement such clauses by program  
16 instruction or otherwise.

17 “(II) Subchapter I of chapter 35  
18 of title 44, United States Code, shall  
19 not apply.

20 “(III) For purposes of carrying  
21 out this subparagraph with respect to  
22 clauses (iii) and (iv) (and clause (vii)  
23 insofar as it relates to clause (iv)),  
24 \$10,000,000 shall be available from  
25 the Federal Supplementary Medical

1 Insurance Trust Fund under section  
2 1841, to remain available until De-  
3 cember 31, 2018.”; and

4 (2) in subparagraph (E), by adding at the end  
5 the following new clause:

6 “(iv) The determination of an audit  
7 under subparagraph (B)(vii).”.

8 (b) **EFFECTIVE DATE.**—The amendments made by  
9 this section shall be effective as if included in the enact-  
10 ment of section 603 of the Bipartisan Budget Act of 2015  
11 (Public Law 114–74).

12 **SEC. 202. TREATMENT OF CANCER HOSPITALS IN OFF-CAM-**  
13 **PUS OUTPATIENT DEPARTMENT OF A PRO-**  
14 **VIDER POLICY.**

15 (a) **IN GENERAL.**—Section 1833(t)(21)(B) of the So-  
16 cial Security Act (42 U.S.C. 1395l(t)(21)(B)), as amended  
17 by section 201(a), is amended—

18 (1) by inserting after clause (v) the following  
19 new clause:

20 “(vi) **EXCLUSION FOR CERTAIN CAN-**  
21 **CER HOSPITALS.**—For purposes of para-  
22 graph (1)(B)(v) and this paragraph with  
23 respect to applicable items and services  
24 furnished during 2017 or a subsequent  
25 year, the term ‘off-campus outpatient de-

1           partment of a provider’ also shall not in-  
2           clude a department of a provider (as so de-  
3           fined) that is not described in clause (ii) if  
4           the provider is a hospital described in sec-  
5           tion 1886(d)(1)(B)(v) and—

6                   “(I) in the case of a department  
7                   that met the requirements of section  
8                   413.65 of title 42 of the Code of Fed-  
9                   eral Regulations after November 1,  
10                  2015, and before the date of the en-  
11                  actment of this clause, the Secretary  
12                  receives from the provider an attesta-  
13                  tion that such department met such  
14                  requirements not later than 60 days  
15                  after such date of enactment; or

16                  “(II) in the case of a department  
17                  that meets such requirements after  
18                  such date of enactment, the Secretary  
19                  receives from the provider an attesta-  
20                  tion that such department meets such  
21                  requirements not later than 60 days  
22                  after the date such requirements are  
23                  first met with respect to such depart-  
24                  ment.”;

1           (2) in clause (vii), by inserting after the first  
2 sentence the following: “Not later than 2 years after  
3 the date the Secretary receives an attestation under  
4 clause (vi) relating to compliance of a department of  
5 a provider with requirements referred to in such  
6 clause, the Secretary shall audit the compliance with  
7 such requirements with respect to the department.”;  
8 and

9           (3) in clause (viii)(III), by adding at the end  
10 the following: “For purposes of carrying out this  
11 subparagraph with respect to clause (vi) (and clause  
12 (vii) insofar as it relates to such clause), \$2,000,000  
13 shall be available from the Federal Supplementary  
14 Medical Insurance Trust Fund under section 1841,  
15 to remain available until expended.”.

16       (b) OFFSETTING SAVINGS.—Section 1833(t)(18) of  
17 the Social Security Act (42 U.S.C. 1395l(t)(18)) is  
18 amended—

19           (1) in subparagraph (B), by inserting “, subject  
20 to subparagraph (C),” after “shall”; and

21           (2) by adding at the end the following new sub-  
22 paragraph:

23                   “(C) TARGET PCR ADJUSTMENT.—In ap-  
24 plying section 419.43(i) of title 42 of the Code  
25 of Federal Regulations to implement the appro-

1           prorate adjustment under this paragraph for  
2           services furnished on or after January 1, 2018,  
3           the Secretary shall use a target PCR that is 1.0  
4           percentage points less than the target PCR that  
5           would otherwise apply. In addition to the per-  
6           centage point reduction under the previous sen-  
7           tence, the Secretary may consider making an  
8           additional percentage point reduction to such  
9           target PCR that takes into account payment  
10          rates for applicable items and services described  
11          in paragraph (21)(C) other than for services  
12          furnished by hospitals described in section  
13          1886(d)(1)(B)(v). In making any budget neu-  
14          trality adjustments under this subsection for  
15          2018 or a subsequent year, the Secretary shall  
16          not take into account the reduced expenditures  
17          that result from the application of this subpara-  
18          graph.”.

19          (c) EFFECTIVE DATE.—The amendments made by  
20          this section shall be effective as if included in the enact-  
21          ment of section 603 of the Bipartisan Budget Act of 2015  
22          (Public Law 114–74).



1 **SEC. 203. TREATMENT OF ELIGIBLE PROFESSIONALS IN**  
2 **AMBULATORY SURGICAL CENTERS FOR**  
3 **MEANINGFUL USE AND MIPS.**

4 (a) IN GENERAL.—Section 1848(a)(7)(D) of the So-  
5 cial Security Act (42 U.S.C. 1395w-4(a)(7)(D)) is amend-  
6 ed—

7 (1) by striking “HOSPITAL-BASED ELIGIBLE  
8 PROFESSIONALS” and all that follows through “No  
9 payment” and inserting the following: “HOSPITAL-  
10 BASED AND AMBULATORY SURGICAL CENTER-BASED  
11 ELIGIBLE PROFESSIONALS.—

12 “(i) HOSPITAL-BASED.—No pay-  
13 ment”; and

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

16 “(ii) AMBULATORY SURGICAL CEN-  
17 TER-BASED.—Subject to clause (iv), no  
18 payment adjustment may be made under  
19 subparagraph (A) for 2017 and 2018 in  
20 the case of an eligible professional with re-  
21 spect to whom substantially all of the cov-  
22 ered professional services furnished by  
23 such professional are furnished in an am-  
24 bulatory surgical center.

25 “(iii) DETERMINATION.—The deter-  
26 mination of whether an eligible profes-

1 sional is an eligible professional described  
2 in clause (ii) may be made on the basis  
3 of—

4 “(I) the site of service (as de-  
5 fined by the Secretary); or

6 “(II) an attestation submitted by  
7 the eligible professional.

8 Determinations made under subclauses (I)  
9 and (II) shall be made without regard to  
10 any employment or billing arrangement be-  
11 tween the eligible professional and any  
12 other supplier or provider of services.

13 “(iv) SUNSET.—Clause (ii) shall no  
14 longer apply as of the first year that be-  
15 gins more than 3 years after the date on  
16 which the Secretary determines, through  
17 notice and comment rulemaking, that cer-  
18 tified EHR technology applicable to the  
19 ambulatory surgical center setting is avail-  
20 able.”.

21 (b) CONTINUED APPLICATION OF CERTAIN PROVI-  
22 SIONS UNDER MIPS.—Section 1848(o)(2)(D) of the So-  
23 cial Security Act (42 U.S.C. 1395w-4(o)(2)(D)) is amend-  
24 ed by adding at the end the following new sentence: “The  
25 provisions of subparagraphs (B) and (D) of subsection

1 (a)(7), including the application of clause (iv) of such sub-  
2 paragraph (D), shall apply to assessments of MIPS eligi-  
3 ble professionals under subsection (q) with respect to the  
4 performance category described in subsection (q)(2)(A)(iv)  
5 in a manner similar to the manner in which such provi-  
6 sions apply with respect to payment adjustments made  
7 under subsection (a)(7)(A).”.

8 **TITLE III—OTHER MEDICARE**  
9 **PROVISIONS**

10 **SEC. 301. DELAY IN AUTHORITY TO TERMINATE CON-**  
11 **TRACTS FOR MEDICARE ADVANTAGE PLANS**  
12 **FAILING TO ACHIEVE MINIMUM QUALITY**  
13 **RATINGS.**

14 (a) FINDINGS.—Consistent with the studies provided  
15 under the IMPACT Act of 2014 (Public Law 113–185),  
16 it is the intent of Congress—

17 (1) to continue to study and request input on  
18 the effects of socioeconomic status and dual-eligible  
19 populations on the Medicare Advantage STARS rat-  
20 ing system before reforming such system with the  
21 input of stakeholders; and

22 (2) pending the results of such studies and  
23 input, to provide for a temporary delay in authority  
24 of the Centers for Medicare & Medicaid Services  
25 (CMS) to terminate Medicare Advantage plan con-

1 tracts solely on the basis of performance of plans  
2 under the STARS rating system.

3 (b) DELAY IN MA CONTRACT TERMINATION AU-  
4 THORITY FOR PLANS FAILING TO ACHIEVE MINIMUM  
5 QUALITY RATINGS.—Section 1857(h) of the Social Secu-  
6 rity Act (42 U.S.C. 1395w–27(h)) is amended by adding  
7 at the end the following new paragraph:

8 “(3) DELAY IN CONTRACT TERMINATION AU-  
9 THORITY FOR PLANS FAILING TO ACHIEVE MINIMUM  
10 QUALITY RATING.—During the period beginning on  
11 the date of the enactment of this paragraph and  
12 through the end of plan year 2018, the Secretary  
13 may not terminate a contract under this section with  
14 respect to the offering of an MA plan by a Medicare  
15 Advantage organization solely because the MA plan  
16 has failed to achieve a minimum quality rating  
17 under the 5-star rating system under section  
18 1853(o)(4).”.

19 **SEC. 302. REQUIREMENT FOR ENROLLMENT DATA REPORT-**  
20 **ING FOR MEDICARE.**

21 Section 1874 of the Social Security Act (42 U.S.C.  
22 1395kk) is amended by adding at the end the following  
23 new subsection:

24 “(g) REQUIREMENT FOR ENROLLMENT DATA RE-  
25 PORTING.—

1           “(1) IN GENERAL.—Each year (beginning with  
2           2016), the Secretary shall submit to the Committees  
3           on Ways and Means and Energy and Commerce of  
4           the House of Representatives and the Committee on  
5           Finance of the Senate a report on Medicare enroll-  
6           ment data (and, in the case of part A, on data on  
7           individuals receiving benefits under such part) as of  
8           a date in such year specified by the Secretary. Such  
9           data shall be presented—

10                   “(A) by Congressional district and State;

11                   and

12                   “(B) in a manner that provides for such  
13                   data based on—

14                           “(i) fee-for-service enrollment (as de-  
15                           fined in paragraph (2));

16                           “(ii) enrollment under part C (includ-  
17                           ing separate for aggregate enrollment in  
18                           MA–PD plans and aggregate enrollment in  
19                           MA plans that are not MA–PD plans); and

20                           “(iii) enrollment under part D.

21           “(2) FEE-FOR-SERVICE ENROLLMENT DE-  
22           FINED.—For purpose of paragraph (1)(B)(i), the  
23           term ‘fee-for-service enrollment’ means aggregate en-  
24           rollment (including receipt of benefits other than  
25           through enrollment) under—

1 “(A) part A only;

2 “(B) part B only; and

3 “(C) both part A and part B.”.

4 **SEC. 303. UPDATING THE WELCOME TO MEDICARE PACK-**  
5 **AGE.**

6 (a) **IN GENERAL.**—Not later than 12 months after  
7 the last day of the period for the request of information  
8 described in subsection (b), the Secretary of Health and  
9 Human Services shall, taking into consideration informa-  
10 tion collected pursuant to subsection (b), update the infor-  
11 mation included in the Welcome to Medicare package to  
12 include information, presented in a clear and simple man-  
13 ner, about options for receiving benefits under the Medi-  
14 care program under title XVIII of the Social Security Act  
15 (42 U.S.C. 1395 et seq.), including through the original  
16 medicare fee-for-service program under parts A and B of  
17 such title (42 U.S.C. 1395c et seq., 42 U.S.C. 1395j et  
18 seq.), Medicare Advantage plans under part C of such title  
19 (42 U.S.C. 1395w–21 et seq.), and prescription drug plans  
20 under part D of such title (42 U.S.C. 1395w–101 et  
21 seq.)). The Secretary shall make subsequent updates to  
22 the information included in the Welcome to Medicare  
23 package as appropriate.

24 (b) **REQUEST FOR INFORMATION.**—Not later than 6  
25 months after the date of the enactment of this Act, the

1 Secretary of Health and Human Services shall request in-  
2 formation, including recommendations, from stakeholders  
3 (including patient advocates, issuers, and employers) on  
4 information included in the Welcome to Medicare package,  
5 including pertinent data and information regarding enroll-  
6 ment and coverage for Medicare eligible individuals.

Passed the House of Representatives June 7, 2016.

Attest:

KAREN L. HAAS,

*Clerk.*