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115TH CONGRESS
1ST SESSION

H. R. 2957

To amend titles XVIII and XIX of the Social Security Act to provide for enhanced payments to rural health care providers under the Medicare and Medicaid programs, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 20, 2017

Mr. GRAVES of Missouri (for himself and Mr. LOEBSACK) 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 titles XVIII and XIX of the Social Security Act to provide for enhanced payments to rural health care providers under the Medicare and Medicaid programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Save Rural Hospitals Act''.

(b) FINDINGS.—Congress finds the following:

(1) More than 60,000,000 individuals in rural areas of the United States rely on rural hospitals and other providers as critical access points to health care.

(2) Access to health care is essential to communities that Americans living in rural areas call home.

(3) Americans living in rural areas are older, poorer, and sicker than Americans living in urban areas.

(4) From January 2010 until January 1, 2017, 80 rural hospitals have closed in the United States, according to the University of North Carolina's Cecil G. Sheps Center for Health Services Research, and the rate of these closures is increasing.

(5) Six hundred and seventy-three hospitals are at risk of closing, according to iVantage's Hospital Strength INDEX study, and such closings would impact 11,700,000 patient encounters, 99,000 community jobs would be lost, 137,000 healthcare jobs would be lost, and 277,000,000,000 would be lost from the gross domestic product (over 10 years).

(6) Rural Medicare beneficiaries already face a number of challenges when trying to access health care services close to home, including the weather,

geography, and cultural, social, and language barriers.

(7) Seventy-seven percent of rural counties in the United States are designated as primary care health professional shortage areas while 9 percent have no physicians at all.

(8) Seniors living in rural areas are forced to travel significant distances for care.

(9) On average, trauma victims in rural areas must travel twice as far as victims in urban areas to the closest hospital, and, as a result, 60 percent of trauma deaths occur in rural areas, even though only 20 percent of Americans live in rural areas.

(10) With the 673 hospitals on the brink of closure, 11,700,000 Americans living in rural areas are on the brink of losing access to the closest emergency room.

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

Sec. 1. Short title; table of contents.

TITLE I—RURAL PROVIDER PAYMENT STABILIZATION

Subtitle A—Rural Hospitals

Sec. 101. Eliminating Medicare sequestration for rural hospitals.
Sec. 102. Reversing cuts to reimbursement of bad debt for critical access hospitals (CAHs) and rural hospitals.
Sec. 103. Extending payment levels for low-volume hospitals and Medicare-dependent hospitals (MDHs).
Sec. 104. Reinstating revised diagnosis-related group payments for MDHs and sole community hospitals (SCHs).

Sec. 105. Reinstating hold harmless treatment for hospital outpatient services for SCHs.
Sec. 106. Delaying application of penalties for failure to be a meaningful electronic health record user.
Sec. 107. Eliminating rural Medicare and Medicaid disproportionate share hospital payment reductions.

Subtitle B—Other Rural Providers

Sec. 111. Making permanent increased Medicare payments for ground ambulance services in rural areas.
Sec. 112. Extending Medicaid primary care payments.

TITLE II—RURAL MEDICARE BENEFICIARY EQUITY

Sec. 201. Equalizing beneficiary copayments for services furnished by CAHs.

TITLE III—REGULATORY RELIEF

Sec. 301. Eliminating 96-hour physician certification requirement with respect to inpatient CAH services.
Sec. 302. Rebasing supervision requirements.
Sec. 303. Reforming practices of recovery audit contractors under Medicare.

TITLE IV—FUTURE OF RURAL HEALTH CARE

Sec. 401. Community outpatient hospital program.
Sec. 402. Grant funding to assist rural hospitals.
Sec. 403. CMMI demonstration of shared savings in rural hospitals.

TITLE I—RURAL PROVIDER PAYMENT STABILIZATION

Subtitle A—Rural Hospitals

SEC. 101. ELIMINATING MEDICARE SEQUESTRATION FOR RURAL HOSPITALS.

(a) IN GENERAL.—Section 256(d)(7) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 906(d)(7)) is amended by adding at the end the following:

"(D) RURAL HOSPITALS.—Payments under part A or part B of title XVIII of the Social Security Act with respect to items and services furnished by a critical access hospital (as

defined in section 1861(mm)(1) of such Act), a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act), a medicare-dependent small rural hospital (as defined in section 1886(d)(5)(G)(iv) of such Act), or a subsection (d) hospital located in a rural area (as defined in section 1886(d)(2)(D) of such Act).''.

(b) APPLICABILITY.—The amendment made by this section applies with respect to orders of sequestration effective on or after the date that is 60 days after the date of the enactment of this Act.

SEC. 102. REVERSING CUTS TO REIMBURSEMENT OF BAD DEBT FOR CRITICAL ACCESS HOSPITALS (CAHS) AND RURAL HOSPITALS.

(a) RURAL HOSPITALS.—Section 1861(v)(1)(T)(v) of the Social Security Act (42 U.S.C. 1395x(v)(1)(T)(v)) is amended by inserting before the period the following: ''or, in the case of a hospital located in a rural area, by 30 percent of such amount otherwise allowable''.

(b) CAHS.—Section 1861(v)(1)(W)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(W)(ii)) is amended by inserting after ''or (V)'' the following: '', a critical access hospital''.

(c) APPLICABILITY.—The amendments made by this section apply with respect to cost reporting periods begin-

ning more than 60 days after the date of the enactment of this Act.

SEC. 103. EXTENDING PAYMENT LEVELS FOR LOW-VOLUME HOSPITALS AND MEDICARE-DEPENDENT HOSPITALS (MDHS).

(a) EXTENSION OF INCREASED PAYMENTS FOR MDHS.—

(1) EXTENSION OF PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)), as amended by section 205(a) of the Medicare Access and CHIP Reauthorization Act of 2015, is amended—

(A) in clause (i), by striking ", and before October 1, 2017"; and

(B) in clause (ii)(II), by striking ", and before October 1, 2017".

(2) CONFORMING AMENDMENTS.—

(A) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)), as amended by section 205(b) of the Medicare Access and CHIP Reauthorization Act of 2015, is amended—

(i) in the matter preceding clause (i), by striking ", and before October 1, 2017"; and

(ii) in clause (iv), by striking "during fiscal year 1998 through fiscal year 2017" and inserting "during or after fiscal year 1998".

(B) EXTENDING THE PERIOD DURING WHICH HOSPITALS CAN DECLINE RECLASSIFICATION AS URBAN.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note), as amended by section 205(b) of the Medicare Access and CHIP Reauthorization Act of 2015, is amended—

(i) by inserting after "2017" the following: "or a subsequent fiscal year"; and

(ii) in subparagraph (C), by inserting after "such reclassification" the following: "during the 1-year period that begins on the date of the notification of the hospital under subparagraph (A)".

(b) EXTENSION OF INCREASED PAYMENTS FOR LOW-VOLUME HOSPITALS.—Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)), as amended by

section 204 of the Medicare Access and CHIP Reauthorization Act of 2015, is amended—

(1) in subparagraph (B)—

(A) in the heading, by inserting after ''INCREASE'' the following: ''THROUGH FISCAL YEAR 2010''; and

(B) by striking ''and for discharges occurring in fiscal year 2018 and subsequent fiscal years'';

(2) in subparagraph (C)(i)—

(A) by striking ''25 road miles (or, with respect to fiscal years 2011 through 2017, 15 road miles)'' and inserting ''15 road miles''; and

(B) by striking ''(or, with respect to fiscal years 2011 through 2017, 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A)'' and inserting ''or 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A''; and

(3) in subparagraph (D)—

(A) by amending the heading to read as follows: ''APPLICABLE PERCENTAGE INCREASE AFTER FISCAL YEAR 2010''; and

(B) by striking ''in fiscal years 2011 through 2017'' and inserting ''in fiscal year 2011 and each subsequent fiscal year''.

SEC. 104. REINSTATING REVISED DIAGNOSIS-RELATED GROUP PAYMENTS FOR MDHS AND SOLE COMMUNITY HOSPITALS (SCHS).

(a) PAYMENTS FOR MDHS AND SCHS FOR VALUE-BASED INCENTIVE PROGRAMS.—Section 1886(o)(7)(D)(ii)(I) of the Social Security Act (42 U.S.C. 1395ww(o)(7)(D)(ii)(I)) is amended by inserting ''or after fiscal year 2018'' after ''2013''.

(b) PAYMENTS FOR MDHS AND SCHS UNDER HOSPITAL READMISSIONS REDUCTION PROGRAM.—Section 1886(q)(2)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(q)(2)(B)(i)) is amended by inserting ''or after fiscal year 2018'' after ''2013''.

SEC. 105. REINSTATING HOLD HARMLESS TREATMENT FOR HOSPITAL OUTPATIENT SERVICES FOR SCHS.

Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in the heading, by striking ''**TEMPORARY**'' and inserting ''**PERMANENT**'';

(2) in subclause (II)—

(A) in the first sentence, by inserting ''or on or after January 1, 2018,'' after ''January 1, 2013,''; and

(B) in the second sentence, by inserting '', or during or after 2018'' after ''or 2012''; and

(3) in subclause (III), in the first sentence, by inserting ''or on or after January 1, 2018,'' after ''January 1, 2013,''.

SEC. 106. DELAYING APPLICATION OF PENALTIES FOR FAILURE TO BE A MEANINGFUL ELECTRONIC HEALTH RECORD USER.

(a) IN GENERAL.—Section 1886(b)(3)(B)(ix)(I) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(ix)(I)) is amended by adding at the end the following: ''In the case of a hospital located in a rural area, each fiscal year referred to in the first sentence of this subclause shall be applied as if it were a reference to the year that is 4 fiscal years later.''.

(b) APPLICABILITY.—The amendment made by this section applies with respect fiscal years beginning after the date of the enactment of this Act.

SEC. 107. ELIMINATING RURAL MEDICARE AND MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENT REDUCTIONS.

(a) MEDICARE.—Section 1886(r)(1) of the Social Security Act (42 U.S.C. 1395ww(r)(1)) is amended by inserting before ''25 percent'' the following: ''(unless such hospital is located in a rural area, as defined in subsection (d)(2)(D))''.

(b) MEDICAID.—Section 1923(f)(3) of the Social Security Act (42 U.S.C.1396r–4(f)(3)) is amended—

(1) in subparagraph (A) by striking ''subparagraph (E)'' and inserting ''subparagraphs (E) and (F)''; and

(2) by adding at the end the following:

''(F) INCREASE IN ALLOTMENTS AND PAYMENTS FOR RURAL HOSPITALS.—

''(i) ALLOTMENTS.—Subject to clause (iii) and notwithstanding subparagraphs (B), (C), and (E), the DSH allotment for a State with respect to a fiscal year that would be determined under this paragraph for the State for the fiscal year if this subparagraph did not apply, shall be increased by the product of—

''(I) the reduction of such State's DSH allotment under paragraph (7)(A)(i)(I) for such fiscal year; and

''(II) the percentage of individuals in the State who receive medical assistance under a State plan under this title and who live in a rural area (as defined in section 1886(d)(2)(D)) of the State.

''(ii) PAYMENTS.—Subject to clause (iii), the payments made to a State under section 1903(a) for each calendar quarter shall be increased by the product of—

''(I) the reduction such State's DSH allotment under paragraph (7)(A)(i)(II) for such fiscal year; and

''(II) the percentage of individuals in the State who receive medical assistance under a State plan under this title and who live in a rural area (as defined in section 1886(d)(2)(D)) of the State.

''(iii) SUPPLEMENT, NOT SUPPLANT.—A State may only receive an increased allotment under clause (i) or an in-

creased payment under clause (ii) if such State provides such assurances as the Secretary may require that any funds made available to such State pursuant to such clauses shall be used to supplement, and not supplant, amounts paid under this section to hospitals in the State that are located in rural areas (as defined in section 1886(d)(2)(D)).''.

(c) APPLICABILITY.—The amendments made by this section apply with respect to fiscal year 2018 and each subsequent fiscal year.

Subtitle B—Other Rural Providers

SEC. 111. MAKING PERMANENT INCREASED MEDICARE PAYMENTS FOR GROUND AMBULANCE SERVICES IN RURAL AREAS.

Section 1834(l)(13) of the Social Security Act (42 U.S.C. 1395m(l)(13)) is amended—

(1) by striking ''**TEMPORARY INCREASE**'' and inserting ''**INCREASE**''; and

(2) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking '', and before January 1, 2018''; and

(B) in clause (i), by striking '', and before January 1, 2018''.

SEC. 112. EXTENDING MEDICAID PRIMARY CARE PAYMENTS.

(a) IN GENERAL.—Section 1902(a)(13)(C) of the Social Security Act (42 U.S.C. 1396a(a)(13)(C)) is amended by inserting after ''2014'' the following: ''(or in the case of a primary care services furnished by a physician located in a rural area, as defined in section 1886(d)(2)(D), furnished in any year)''.

(b) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by this section applies to services furnished in a year beginning on or after the date of the enactment of this Act.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the

State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

TITLE II—RURAL MEDICARE BENEFICIARY EQUITY

SEC. 201. EQUALIZING BENEFICIARY COPAYMENTS FOR SERVICES FURNISHED BY CAHS.

(a) IN GENERAL.—Section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following: ''In the case of outpatient critical access hospital services for which payment is made under section 1834(g), clause (ii) of the first sentence shall be applied by substituting '20 percent of the lesser of the actual charge or the payment basis under this part for such services if the critical access hospital were treated as a hospital' for '20 per centum of the reasonable charge for such items and services'.''.

(b) APPLICABILITY.—The amendment made by this section applies with respect to services furnished during a year that begins more than 60 days after the date of the enactment of this Act.

TITLE III—REGULATORY RELIEF

SEC. 301. ELIMINATING 96-HOUR PHYSICIAN CERTIFICATION REQUIREMENT WITH RESPECT TO INPATIENT CAH SERVICES.

(a) IN GENERAL.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

(1) in paragraph (6), by adding ''and'' at the end;

(2) in paragraph (7)(E), by striking ''; and'' and inserting a period; and

(3) by striking paragraph (8).

(b) APPLICABILITY.—The amendments made by this section apply with respect to services furnished during a year that begins more than 60 days after the date of the enactment of this Act.

SEC. 302. REBASING SUPERVISION REQUIREMENTS.

(a) THERAPEUTIC HOSPITAL OUTPATIENT SERVICES.—

(1) SUPERVISION REQUIREMENTS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following:

''(aa) PHYSICIAN SUPERVISION REQUIREMENTS FOR THERAPEUTIC HOSPITAL OUTPATIENT SERVICES.—

''(1) GENERAL SUPERVISION FOR THERAPEUTIC SERVICES.—Except as may be provided under para-

graph (2), insofar as the Secretary requires the supervision by a physician or a non-physician practitioner for payment for therapeutic hospital outpatient services (as defined in paragraph (5)(A)) furnished under this part, such requirement shall be met if such services are furnished under the general supervision (as defined in paragraph (5)(B)) of the physician or non-physician practitioner, as the case may be.

''(2) EXCEPTIONS PROCESS FOR HIGH-RISK OR COMPLEX MEDICAL SERVICES REQUIRING A DIRECT LEVEL OF SUPERVISION.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the Secretary shall establish a process for the designation of therapeutic hospital outpatient services furnished under this part that, by reason of complexity or high risk, require—

''(i) direct supervision (as defined in paragraph (5)(C)) for the entire service; or

''(ii) direct supervision during the initiation of the service followed by general supervision for the remainder of the service.

"(B) CONSULTATION WITH CLINICAL EXPERTS.—

"(i) IN GENERAL.—Under the process established under subparagraph (A), before the designation of any therapeutic hospital outpatient service for which direct supervision may be required under this part, the Secretary shall consult with a panel of outside experts described in clause (ii) to advise the Secretary with respect to each such designation.

"(ii) ADVISORY PANEL ON SUPERVISION OF THERAPEUTIC HOSPITAL OUTPATIENT SERVICES.—For purposes of clause (i), a panel of outside experts described in this clause is a panel appointed by the Secretary, based on nominations submitted by hospital, rural health, and medical organizations representing physicians, non-physician practitioners, and hospital administrators, as the case may be, that meets the following requirements:

"(I) COMPOSITION.—The panel shall be composed of at least 15 physicians and non-physician practi-

tioners who furnish therapeutic hospital outpatient services for which payment is made under this part and who collectively represent the medical specialties that furnish such services, and of 4 hospital administrators of hospitals located in rural areas (as defined in section 1886(d)(2)(D)) or critical access hospitals.

''(II) PRACTICAL EXPERIENCE REQUIRED FOR PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS.—During the 12-month period preceding appointment to the panel by the Secretary, each physician or non-physician practitioner described in subclause (I) shall have furnished therapeutic hospital outpatient services for which payment was made under this part.

''(III) MINIMUM RURAL REPRESENTATION REQUIREMENT FOR PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS.—Not less than 50 percent of the membership of the

panel that is comprised of physicians and non-physician practitioners shall be physicians or non-physician practitioners described in subclause (I) who practice in rural areas (as defined in section 1886(d)(2)(D)) or who furnish such services in critical access hospitals.

''(iii) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. 2 App.), other than section 14 of such Act, shall apply to the panel of outside experts appointed by the Secretary under clause (ii).

''(C) SPECIAL RULE FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—Insofar as a therapeutic outpatient hospital service that is an outpatient critical access hospital service is designated as requiring direct supervision under the process established under subparagraph (A), the Secretary shall deem the critical access hospital furnishing that service as having met the requirement for direct supervision for that service if, when furnishing such service, the critical access hospital meets the

standard for personnel required as a condition of participation under section 485.618(d) of title 42, Code of Federal Regulations (as in effect on the date of the enactment of this subsection).

''(D) CONSIDERATION OF COMPLIANCE BURDENS.—Under the process established under subparagraph (A), the Secretary shall take into account the impact on hospitals and critical access hospitals in complying with requirements for direct supervision in the furnishing of therapeutic hospital outpatient services, including hospital resources, availability of hospital-privileged physicians, specialty physicians, and non-physician practitioners, and administrative burdens.

''(E) REQUIREMENT FOR NOTICE AND COMMENT RULEMAKING.—Under the process established under subparagraph (A), the Secretary shall only designate therapeutic hospital outpatient services requiring direct supervision under this part through proposed and final rulemaking that provides for public notice and opportunity for comment.

''(F) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing the Secretary to apply or require any level of supervision other than general or direct supervision with respect to the furnishing of therapeutic hospital outpatient services.

''(3) INITIAL LIST OF DESIGNATED SERVICES.—The Secretary shall include in the proposed and final regulation for payment for hospital outpatient services for 2018 under this part a list of initial therapeutic hospital outpatient services, if any, designated under the process established under paragraph (2)(A) as requiring direct supervision under this part.

''(4) DIRECT SUPERVISION BY NON-PHYSICIAN PRACTITIONERS FOR CERTAIN HOSPITAL OUTPATIENT SERVICES PERMITTED.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a non-physician practitioner may directly supervise the furnishing of—

''(i) therapeutic hospital outpatient services under this part, including cardiac rehabilitation services (under section 1861(eee)(1)), intensive cardiac rehabilita-

tion services (under section 1861(eee)(4)), and pulmonary rehabilitation services (under section 1861(fff)(1)); and

"(ii) those hospital outpatient diagnostic services (described in section 1861(s)(2)(C)) that require direct supervision under the fee schedule established under section 1848.

"(B) REQUIREMENTS.—Subparagraph (A) shall apply insofar as the non-physician practitioner involved meets the following requirements:

"(i) SCOPE OF PRACTICE.—The non-physician practitioner is acting within the scope of practice under State law applicable to the practitioner.

"(ii) ADDITIONAL REQUIREMENTS.—The non-physician practitioner meets such requirements as the Secretary may specify.

"(5) DEFINITIONS.—In this subsection:

"(A) THERAPEUTIC HOSPITAL OUTPATIENT SERVICES.—The term 'therapeutic hospital outpatient services' means hospital services described in section 1861(s)(2)(B) fur-

nished by a hospital or critical access hospital and includes—

"(i) cardiac rehabilitation services and intensive cardiac rehabilitation services (as defined in paragraphs (1) and (4), respectively, of section 1861(eee)); and

"(ii) pulmonary rehabilitation services (as defined in section 1861(fff)(1)).

"(B) GENERAL SUPERVISION.—

"(i) OVERALL DIRECTION AND CONTROL OF PHYSICIAN.—Subject to clause (ii), with respect to the furnishing of therapeutic hospital outpatient services for which payment may be made under this part, the term 'general supervision' means such services that are furnished under the overall direction and control of a physician or non-physician practitioner, as the case may be.

"(ii) PRESENCE NOT REQUIRED.—For purposes of clause (i), the presence of a physician or non-physician practitioner is not required during the performance of the procedure involved.

"(C) DIRECT SUPERVISION.—

"(i) PROVISION OF ASSISTANCE AND DIRECTION.—Subject to clause (ii), with respect to the furnishing of therapeutic hospital outpatient services for which payment may be made under this part, the term 'direct supervision' means that a physician or non-physician practitioner, as the case may be, is immediately available (including by telephone or other means) to furnish assistance and direction throughout the furnishing of such services. Such term includes, with respect to the furnishing of a therapeutic hospital outpatient service for which payment may be made under this part, direct supervision during the initiation of the service followed by general supervision for the remainder of the service (as described in paragraph (2)(A)(ii)).

"(ii) PRESENCE IN ROOM NOT REQUIRED.—For purposes of clause (i), a physician or non-physician practitioner, as the case may be, is not required to be present in the room during the performance of the procedure involved or within

any other physical boundary as long as the physician or non-physician practitioner, as the case may be, is immediately available.

''(D) NON-PHYSICIAN PRACTITIONER DEFINED.—The term 'non-physician practitioner' means an individual who—

''(i) is a physician assistant, a nurse practitioner, a clinical nurse specialist, a clinical social worker, a clinical psychologist, a certified nurse midwife, or a certified registered nurse anesthetist, and includes such other practitioners as the Secretary may specify; and

''(ii) with respect to the furnishing of therapeutic outpatient hospital services, meets the requirements of paragraph (4)(B).''.

(2) CONFORMING AMENDMENT.—Section 1861(eee)(2)(B) of the Social Security Act (42 U.S.C. 1395x(eee)(2)(B)) is amended by inserting '', and a non-physician practitioner (as defined in section 1833(aa)(5)(D)) may supervise the furnishing of such items and services in the hospital'' after ''in the case of items and services furnished under such

a program in a hospital, such availability shall be presumed''.

(b) PROHIBITION ON RETROACTIVE ENFORCEMENT OF REVISED INTERPRETATION.—

(1) REPEAL OF REGULATORY CLARIFICATION.—The restatement and clarification under the final rulemaking changes to the Medicare hospital outpatient prospective payment system and calendar year 2009 payment rates (published in the Federal Register on November 18, 2008, 73 Fed. Reg. 68702 through 68704) with respect to requirements for direct supervision by physicians for therapeutic hospital outpatient services (as defined in paragraph (3)) for purposes of payment for such services under the Medicare program shall have no force or effect in law.

(2) HOLD HARMLESS.—A hospital or critical access hospital that furnishes therapeutic hospital outpatient services during the period beginning on January 1, 2001, and ending on the later of December 31, 2017, or the date on which the final regulation promulgated by the Secretary of Health and Human Services to carry out this section takes effect, for which a claim for payment is made under part B of title XVIII of the Social Security Act shall

not be subject to any civil or criminal action or penalty under Federal law for failure to meet supervision requirements under the regulation described in paragraph (1), under program manuals, or otherwise.

(3) THERAPEUTIC HOSPITAL OUTPATIENT SERVICES DEFINED.—In this subsection, the term ''therapeutic hospital outpatient services'' means medical and other health services furnished by a hospital or critical access hospital that are—

(A) hospital services described in subsection (s)(2)(B) of section 1861 of the Social Security Act (42 U.S.C. 1395x);

(B) cardiac rehabilitation services or intensive cardiac rehabilitation services (as defined in paragraphs (1) and (4), respectively, of subsection (eee) of such section); or

(C) pulmonary rehabilitation services (as defined in subsection (fff)(1) of such section).

SEC. 303. REFORMING PRACTICES OF RECOVERY AUDIT CONTRACTORS UNDER MEDICARE.

(a) ELIMINATION OF CONTINGENCY FEE PAYMENT SYSTEM.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)), as amended by section 505(b) of the

Medicare Access and CHIP Reauthorization Act of 2015, is amended—

(1) in paragraph (1), by inserting ", for recovery activities conducted during a fiscal year before fiscal year 2016" after "Under the contracts"; and

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

"(11) PAYMENT FOR RECOVERY ACTIVITIES PERFORMED AFTER FISCAL YEAR 2017.—

"(A) IN GENERAL.—Under the contracts, subject to subparagraphs (B) and (C), payment shall be made to recovery audit contractors for recovery activities conducted during fiscal year 2018 and each fiscal year thereafter in the same manner, and from the same amounts, as payment is made to eligible entities under contracts entered into for recovery activities conducted during fiscal year 2015 under subsection (a).

"(B) PROHIBITION ON INCENTIVE PAYMENTS.—Under the contracts, payment made to a recovery audit contractor for recovery activities conducted during fiscal year 2018 or any fiscal year thereafter may not include any incentive payments.

"(C) PERFORMANCE ACCOUNTABILITY.—

"(i) IN GENERAL.—Under the contracts, payment made to a recovery audit contractor for recovery activities conducted during fiscal year 2018 or any fiscal year thereafter shall, in the case that the contractor has a complex audit denial overturn rate at the end of such fiscal year (as calculated under the methodology described in clause (iv)) that is .1 or greater, be reduced in an amount determined in accordance with clause (ii).

"(ii) PAYMENT REDUCTIONS.—

"(I) SLIDING SCALE OF AMOUNT OF REDUCTIONS.—The Secretary shall establish, for purposes of determining the amount of a reduction in payment to a recovery audit contractor under clause (i) for recovery activities conducted during fiscal year, a linear sliding scale of payment reductions for recovery audit contractors for such fiscal year. Under such linear sliding scale, the amount of such a reduction in payment to a re-

covery audit contractor for a fiscal year shall be calculated in a manner that provides for such reduction to be greater than the reduction for such fiscal year for recovery audit contractors that have complex audit denial overturn rates at the end of such fiscal year (as calculated under the methodology described in clause (iv)) that are lower than the complex audit denial overturn rate of the contractor at the end of such fiscal year (as so calculated).

''(II) MANNER OF COLLECTING REDUCTION.—The Secretary may assess and collect the reductions in payment to recovery audit contractors under clause (i) in such manner as the Secretary may specify (such as by reducing the amount paid to the contractor for recovery activities conducted during a fiscal year or by assessing the reduction as a separate penalty payment to be paid to the Secretary by the contractor with re-

spect to each complex audit denial issued by the contractor that is overturned on appeal).

''(iii) TIMING OF DETERMINATIONS OF PAYMENT REDUCTIONS.—The Secretary shall, with respect to a recovery audit contractor, determine not later than six months after the end of a fiscal year—

''(I) whether to reduce payment to the recovery audit contractor under clause (i) for recovery activities conducted during such fiscal year; and

''(II) in the case that the Secretary determines to so reduce payment to the contractor, the amount of such payment reduction.

''(iv) METHODOLOGY FOR CALCULATION OF OVERTURNED COMPLEX AUDIT DENIAL OVERTURN RATE.—

''(I) CALCULATION OF OVERTURN RATE.—The Secretary shall calculate a complex audit denial overturn rate for a recovery audit contractor for a fiscal year by—

"(aa) determining, with respect to the contract entered into under paragraph (1) by the contractor, the number of complex audit denials issued by the contractor under the contract (including denials issued before such fiscal year and during such fiscal year) that are overturned on appeal; and

"(bb) dividing the number determined under item (aa) by the number of complex audit denials issued by the contractor under such contract (including denials issued before such fiscal year and during such fiscal year).

"(II) FAIRNESS AND TRANSPARENCY.—The Secretary shall calculate the percentage described in subclause (I) in a fair and transparent manner.

"(III) ACCOUNTING FOR SUBSEQUENTLY OVERTURNED APPEALS.—The Secretary shall calculate the per-

centage described in subclause (I) in a manner that accounts for the likelihood that complex audit denials issued by the contractor for such fiscal year will be overturned on appeal in a subsequent fiscal year.

''(IV) COMPLEX AUDIT DENIAL DEFINED.—In this subparagraph, the term 'complex audit denial' means a denial by a recovery audit contractor of a claim for payment under this title submitted by a hospital, psychiatric hospital, or critical access hospital that is so denied by the contractor after the contractor has—

''(aa) requested that the hospital, psychiatric hospital, or critical access hospital, in order to support such claim for payment, provide supporting medical records to the contractor; and

''(bb) reviewed such medical records in order to determine whether an improper payment has been made to the hospital,

psychiatric hospital, or critical access hospital for such claim.

''(V) OVERTURNED ON APPEAL DEFINED.—In this subparagraph, the term 'overturned on appeal' means, with respect to a complex audit denial, a denial that is overturned on appeal at the reconsideration level, the redetermination level, or the administrative law judge hearing level.

''(D) APPLICATION TO EXISTING CONTRACTS.—Not later than 60 days after the date of the enactment of this paragraph, the Secretary shall modify, as necessary, each contract under paragraph (1) that the Secretary entered into prior to such date of enactment in order to ensure that payment with respect to recovery activities conducted under such contract is made in accordance with the requirements described in this paragraph.''.

(b) ELIMINATION OF ONE-YEAR TIMELY FILING LIMIT TO REBILL PART B CLAIMS.—

(1) IN GENERAL.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

''(20) EXCEPTION TO THE ONE-YEAR TIMELY FILING LIMIT FOR CERTAIN REBILLED CLAIMS.—

''(A) IN GENERAL.—In the case of a claim submitted under this part by a hospital (as defined in subparagraph (B)(i)) for hospital services with respect to which there was a previous claim submitted under part A as inpatient hospital services or inpatient critical access hospital services that was denied by a medicare contractor (as defined in subparagraph (B)(ii)) because of a determination that the inpatient admission was not medically reasonable and necessary under section 1862(a)(1)(A), the deadline described in this paragraph is 180 days after the date of the final denial of such claim under part A.

''(B) DEFINITIONS.—In this paragraph:

''(i) HOSPITAL.—The term 'hospital' has the meaning given such term in section 1861(e) and includes a psychiatric hospital (as defined in section 1861(f)) and a critical access hospital (as defined in section 1861(mm)(1)).

''(ii) MEDICARE CONTRACTOR.—The term 'medicare contractor' has the mean-

ing given such term under section 1889(g), and includes a recovery audit contractor with a contract under section 1893(h).

''(iii) FINAL DENIAL.—The term 'final denial' means—

''(I) in the case that a hospital elects not to appeal a denial described in subparagraph (A) by a medicare contractor, the date of such denial; or

''(II) in the case that a hospital elects to appeal a such a denial, the date on which such appeal is exhausted.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1835(a)(1) of the Social Security Act (42 U.S.C. 1395n(a)(1)) is amended by inserting ''or, in the case of a claim described in section 1842(b)(20), not later than the deadline described in such paragraph'' after ''the date of service''.

(B) Section 1842(b)(3)(B) of the Social Security Act (42 U.S.C. 1395u(b)(3)(B)) is amended in the flush language following clause (ii) by inserting ''or, in the case of a claim described in section 1842(b)(20), not later than

the deadline described in such paragraph'' after ''the date of service''.

(3) APPLICABILITY.—The amendments made by this subsection apply to claims submitted under part B of title XVIII of the Social Security Act for hospital services for which there was a previous claim submitted under part A as inpatient hospital services or inpatient critical access hospital services that was subject to a final denial (as defined in paragraph (20)(B)(iii) of section 1842(b) of such Act (42 U.S.C. 1395u(b))) on or after the date of the enactment of this Act.

(c) MEDICAL DOCUMENTATION CONSIDERED FOR MEDICAL NECESSITY REVIEWS OF CLAIMS FOR INPATIENT HOSPITAL SERVICES.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended by adding at the end the following new sentence: ''A determination under paragraph (1) of whether inpatient hospital services or inpatient critical access hospital services furnished to an individual on or after the date of the enactment of this sentence are reasonable and necessary shall be based solely upon information available to the admitting physician at the time of the inpatient admission of the individual for such inpatient services, as documented in the medical record.''.

TITLE IV—FUTURE OF RURAL HEALTH CARE

SEC. 401. COMMUNITY OUTPATIENT HOSPITAL PROGRAM.

(a) IN GENERAL.—

(1) COMMUNITY OUTPATIENT HOSPITAL AND QUALIFIED OUTPATIENT SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(A) in the last sentence of subsection (e), by inserting before the period at the end ''or a community outpatient hospital (as defined in subsection (iii)(1))''; and

(B) by adding at the end the following:

''Community Outpatient Hospital

''(iii)(1) The term 'community outpatient hospital' means a facility that—

''(A) at any time during the period beginning on the date that is 5 years before the date of the enactment of this subsection and ending on December 31, 2016, was a critical access hospital, or is a hospital with not more than 50 beds that is—

''(i) located in a rural area (as defined in section 1886(d)(2)(D)); or

''(ii) treated as being located in a rural area under section 1886(d)(8)(E);

''(B) provides emergency medical care and observation care available on a 24-hour basis;

''(C) with respect to continuous care for an individual, does not provide care over two or more consecutive midnights;

''(D) does not provide any acute care inpatient beds and has protocols in place for the timely transfer of patients who require other inpatient services;

''(E) has the resources required of a level IV or higher trauma center (as verified by the American College of Surgeons or other means specified by the Secretary), or has available for consultation on a 24-hour basis a health care professional who successfully completed the Advanced Trauma Life Support Course offered by the American College of Surgeons (or an equivalent course as determined by the Secretary) within the preceding 4 years;

''(F) has in effect a transfer agreement with a level I or level II trauma center designated under section 1231(1) of the Public Health Service Act;

''(G) meets the requirements of subsection (aa)(2)(I);

''(H) has been approved by the State in which the facility is located for treatment as a community outpatient hospital;

''(I) notifies the Secretary at such time and in such manner as the Secretary may require of the intent of such facility to be designated as a community outpatient facility; and

''(J) meets such staff training and certification requirements as the Secretary may require.

''(2) Nothing in this subsection or section 1834(r) shall be construed to prohibit a community outpatient hospital from having an agreement under section 1883 for the provision of extended care services.

''(3) Unless the context otherwise requires, a reference to a community outpatient hospital in this title shall be deemed to also be a reference to a critical access hospital.

''Qualified Outpatient Services

''(jjj) The term 'qualified outpatient services' means medical and other health services furnished on an outpatient basis by a community outpatient hospital, rural health clinic (as defined in section 1861(aa)(2)), federally qualified health center (as defined in section 1861(aa)(4)), or an entity certified by the Health Resources and Services Administration as a federally qualified health center look-alike, including, for individuals who require services from a hospital or critical access hospital, transportation serv-

ices from such community outpatient hospital to a hospital or critical access hospital.''.

(2) PAYMENT FOR QUALIFIED OUTPATIENT SERVICES.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following:

''(r) PAYMENT FOR QUALIFIED OUTPATIENT SERVICES.—

''(1) IN GENERAL.—The amount of payment for qualified outpatient services is equal to 105 percent of the reasonable costs of providing such services.

''(2) TELEHEALTH SERVICES AS REASONABLE COSTS.—For purposes of this subsection, with respect to qualified outpatient services, costs reasonably associated with having a backup physician available via a telecommunications system shall be considered reasonable costs.''.

(b) WAIVER OF DISTANCE REQUIREMENT FOR REPLACEMENT CAHS; SUBSEQUENT REDESIGNATION OF COMMUNITY OUTPATIENT HOSPITALS AS CAHS.—Section 1820(c)(2) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)) is amended—

(1) in subparagraph (B)(i)(I), by inserting ", subject to subparagraph (F)," before "is located"; and

(2) by adding at the end the following:

"(F) OPTION TO WAIVE DISTANCE REQUIREMENT.—The State may waive the distance requirement described in subparagraph (B)(i)(I) with respect to a facility located in the State that is seeking designation as a critical access hospital under this paragraph if the total number of waivers for such facilities does not exceed the number of facilities that are critical access hospitals without such a waiver.

"(G) REDESIGNATION OF A CRITICAL ACCESS HOSPITAL AS A COMMUNITY OUTPATIENT HOSPITAL.—A community outpatient hospital may elect to be redesignated as a community outpatient hospital by notifying the Secretary at the same time and in the same manner as notifications under section 1861(iii)(1)(I) if such community outpatient hospital—

"(i) meets the requirements in paragraphs (1) and (3) of section 1820(e); and

"(ii) was designated as a critical access hospital under this paragraph on the

date that the Secretary first considered such community outpatient hospital to be a community outpatient hospital.''.

(c) CONFORMING AMENDMENTS.—

(1) REASONABLE COST FOR COHS.—Section 1861(v)(7) of the Social Security Act (42 U.S.C. 1395x(v)(7)) is amended by adding at the end the following:

''(E) For additional items included in reasonable cost for community outpatient hospitals and for determination of payment amounts for qualified outpatient services, see section 1834(r).''.

(2) COHS AS COVERED SERVICES.—Section 1832(a)(2)(H) of the Social Security Act (42 U.S.C. 1395k(a)(2)(H)) is amended by inserting ''and qualified outpatient services (as defined in section 1861(iii)(2))'' before the semicolon.

(3) COH PAYMENTS.—Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (8), by striking ''; and'';

(B) in paragraph (9), by striking the period at the end and inserting ''; and''; and

(C) by inserting after paragraph (9) the following:

''(10) in the case of qualified outpatient services, the amounts described in section 1834(r).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after the first day of the first calendar year beginning more than 1 year after the date of the enactment of this Act.

(d) REPORTS.—The Secretary of Health and Human Services shall submit to Congress three reports on the impact of community outpatient hospitals on the availability of health care and health outcomes in rural areas (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) as follows:

(1) INITIAL REPORT.—An initial report approximately 2 years after the date of the enactment of this Act.

(2) INTERIM REPORT.—An interim report approximately 5 years after the date of the enactment of this Act.

(3) FINAL REPORT.—A final report approximately 10 years after the date of the enactment of this Act.

SEC. 402. GRANT FUNDING TO ASSIST RURAL HOSPITALS.

Section 330A of the Public Health Service Act (42 U.S.C. 254c) is amended—

(1) in subsection (b)—

(A) in paragraph (1), by striking ''Director specified in subsection (d)'' and inserting ''Director of the Office of Rural Health Policy of the Health Resources and Services Administration''; and

(B) by adding at the end the following:

''(6) ELIGIBLE RURAL HOSPITAL.—The term 'eligible rural hospital' means—

''(A) a hospital (as defined in section 1861(e) of the Social Security Act) that—

''(i) has fewer than 50 beds; and

''(ii) is located in a rural area (as defined in section 1886(d)(2)(D) of such Act) or treated as being located in a rural area pursuant to section 1886(d)(8)(E) of such Act;

''(B) a community outpatient hospital (as defined in section 1861(iii) of such Act); or

''(C) a critical access hospital (as defined in section 1861(mm) of such Act).''; and

(2) by adding at the end the following:

''(i) QUALITY IMPROVEMENT AND COMPLIANCE GRANTS FOR ELIGIBLE RURAL HOSPITALS.—

''(1) GRANTS.—The Director may award grants to eligible rural hospitals to assist such hospitals with reporting on quality and to prepare such hospitals to transition to value-based reimbursement.

''(2) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible rural hospital shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including a description of—

''(A) how the eligible rural hospital will use the funds provided under the grant; and

''(B) how the project will be evaluated.

''(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for each fiscal year (beginning with fiscal year 2019) $12,000,000 to carry out this subsection.

''(j) OUTREACH GRANTS FOR RURAL HOSPITAL POPULATION HEALTH.—

''(1) GRANTS.—To help eligible rural hospitals meet a specific community need identified in a community needs assessment, the Director may award grants to eligible rural hospitals.

''(2) LIMITATION ON SIZE OF GRANTS TO COHS.—The Secretary may not award more than

$650,000 each fiscal year to a community outpatient hospital that is described in subsection (b)(6)(B).

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible rural hospital shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) a description of how the eligible rural hospital will use the funds provided under the grant;

''(B) the results of community needs assessment that identified the specific community need described in paragraph (1); and

''(C) a description of how the project will be evaluated.

''(4) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for each fiscal year (beginning with fiscal year 2019)—

''(A) $15,000,000 for grants to eligible rural hospitals described in subparagraphs (A) and (C) of subsection (b)(6); and

''(B) $50,000,000 for grants to eligible rural hospitals described in subparagraph (B) of such subsection.

''(k) EMS GRANT FUNDING.—

''(1) GRANTS.—The Director may award grants to eligible rural hospitals to develop and implement strategies to develop successful emergency medical services programs that meet community needs, provide quality care, and address workforce and funding problems.

''(2) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible rural hospital shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including a description of—

''(A) how the eligible rural hospital will use the funds provided under the grant;

''(B) any multistate collaborations involved in using such funds; and

''(C) how the use of funds will be evaluated.

''(3) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for each fiscal year (beginning with fiscal year 2019) $2,000,000 to carry out this subsection.''.

SEC. 403. CMMI DEMONSTRATION OF SHARED SAVINGS IN RURAL HOSPITALS.

Section 1115A(b)(2)(B) of the Social Security Act (42 U.S.C. 1315a(b)(2)(B)) is amended by adding at the end the following:

"(xxv) Promoting greater shared savings with hospitals located in rural areas, with critical access hospitals (as defined in section 1861(mm)(1)), and with community outpatient hospitals (as defined in section 1861(iii)(1)).".

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